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Maryland Total Cost of Care Model
Maryland Primary Care Program
Request for Applications

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Abstract

This is the final planned Request for Applications (RFA) CMS will release for participation in the Maryland Primary Care Program (MDPCP). Strengthening primary care is critical to promoting health and reducing overall health care costs in Maryland. The Centers for Medicare & Medicaid Services (CMS) announced the Maryland Total Cost of Care (TCOC) Model (the “Model”) on May 14, 2018. The Model sets Maryland on course to achieve fixed amounts of savings to Medicare per capita total cost of care during each model year. The Model’s financial targets are structured to obtain a total of over \$1 billion in Medicare total cost of care savings by the fifth performance year of the Model.

The Maryland TCOC Model includes three component programs: the Hospital Payment Program (HPP), which continues the hospital global budgets of the successful earlier [the Maryland All-Payer Model](#) that holds hospitals accountable for reducing unnecessary hospitalizations; the Care Redesign Program (CRP), which allows Maryland hospitals to enter into financial arrangements with nonhospital providers and suppliers to incentivize collaboration across different care delivery settings; and the Maryland Primary Care Program (MDPCP), which provides additional resources and incentives to participating primary care providers and Federally Qualified Health Centers (FQHCs) to enable patient-centered care management, implement preventive care interventions in an effort to reduce unnecessary hospital utilization and improve health outcomes. This RFA is for participation in the MDPCP only.

The Model began on January 1, 2019. As part of the Model, CMS is offering primary care practices and FQHCs in the state of Maryland (the “State”) the opportunity to participate in the MDPCP. Building on the [Comprehensive Primary Care Plus](#) (CPC+) Model, the [Primary Care First](#) (PCF) Model, as well as input received in response to the 2015 Request for Information on Advanced Primary Care Model Concepts, CMS believes that the MDPCP can reduce costs and improve the quality of care for Maryland Medicare beneficiaries in a manner that is aligned with the goals of the Model.

Primary care practices and FQHCs participating in the MDPCP (“Participant Practices” and “Participant FQHCs,” respectively, collectively “MDPCP Participants”) are expected to transform the way they deliver primary care in order to provide comprehensive care management and beneficiary-centered care. CMS will support primary care practices’ and FQHCs’ transformation efforts by making payments for enhanced care management as well as performance-based payments to MDPCP Participants. All eligible primary care practices and FQHCs within the State are invited to apply to participate in the MDPCP. Additionally, CMS is accepting applications from entities that wish to participate in the initiative as a “Care Transformation Organization” (CTO), which, for the purposes of this Model, is defined as an entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to MDPCP Participants.

The first Performance Year of the MDPCP began on January 1, 2019, and the final Performance Year will end on December 31, 2026. During Performance Years 2019 and 2020, participation in the MDPCP was limited to Participant Practices and CTOs. Participant FQHCs were added to the MDPCP beginning in Performance Year 2021.

During Performance Years 2020 through 2022, the initiative has had two tracks for Participant Practices (Track 1 and Track 2), with increased care redesign expectations and payments for Participant Practices in Track 2. While FQHCs were eligible to participate only in Track 1 during Performance Year 2021, FQHCs became eligible to participate in Track 2 beginning in Performance Year 2022.

CMS introduced Track 3 in Performance Year 2023. Track 3 builds on lessons learned from MDPCP Tracks 1 and 2 and the introduction of CMS' PCF Model, as well as stakeholder feedback from current MDPCP Participants and the Maryland Department of Health (MDH). Track 3 further aligns with the goals of the Model to test whether population-based payments (PBPs), in conjunction with State-wide health care delivery transformation, improve population health and care outcomes for individuals, while controlling the growth of Medicare TCOC. FQHCs are not currently eligible to participate in Track 3.

Performance Year 2023 is the last Performance Year for MDPCP Participants to participate in Track 1 of the MDPCP. By Performance Year 2024, all Practice Participants must participate in Track 2 or Track 3 of the MDPCP and all FQHC Participants must participate in Track 2 of the MDPCP.

This RFA is for eligible primary care practices, eligible FQHCs, and eligible CTOs to apply to participate in the MDPCP beginning in Performance Year 2024 (“Applicant Practices,” “Applicant FQHCs,” and “Applicant CTOs,” respectively, collectively “MDPCP Applicants”).

During the application process, Applicant FQHCs may apply only to Track 2; Applicant Practices may indicate a preference for participating in Track 2 or Track 3. CMS will take Applicant Practices' preference into account when considering the Track to which the Applicant Practice will be assigned if selected to participate in the MDPCP. However, if an Applicant Practice that indicates a preference to participate in Track 3 is selected to participate in the MDPCP, CMS reserves the right to assign the Applicant Practice to Track 2 based on CMS' assessment of the practice's readiness to meet the applicable care transformation requirements for Track 3. Please see [Appendix 2: Tentative Care Transformation Requirements](#) for additional information. Participant Practices that are assigned to Track 2 for Performance Year 2024 are expected to transition along the continuum towards comprehensive primary care and must transition to Track 3 no later than Performance Year 2026. Participant FQHCs are also expected to transition along the continuum towards comprehensive primary care, though CMS and the State may consider allowing Participant FQHCs to continue to participate in MDPCP Track 2 for the duration of the MDPCP performance period.

MDPCP Overview

Under the authority of section 1115A of the Social Security Act (the “Act”), CMS in consultation with the State has designed the MDPCP, a primary care delivery and payment redesign initiative within the Model. The MDPCP builds on the progress achieved under [the Maryland All-Payer Model](#) and helps health care providers in Maryland adjust to total cost of care accountability under the Model.

The MDPCP aims to transform primary care in Maryland, increasing practitioners’ capacity to provide comprehensive primary care. For the purposes of the MDPCP, comprehensive primary care is defined as meeting the following five Comprehensive Primary Care Functions of Advanced Primary Care:

- Care Management
- Access and Continuity
- Planned Care for Health Outcomes
- Beneficiary and Caregiver Experience
- Comprehensiveness and Coordination Across the Continuum of Care

All MDPCP Practices must perform these five Comprehensive Primary Care Functions of Advanced Primary Care by meeting a set of care transformation requirements specific to each such function as specified in Appendix 2: Tentative Care Transformation Requirements. On a semiannual basis, CMS will assess the status and progress of MDPCP Participants in meeting these care transformation requirements. CMS and the MDH will support MDPCP Participants in meeting the care transformation requirements via program guides and ongoing Learning Network activities. (Refer to Section IV. of this RFA for additional information regarding the CMS MDPCP Learning Network.)

To facilitate this care transformation, the MDPCP has offered multiple Tracks for participation. The MDPCP offers Track 2 MDPCP Participants a combination of prospective per-beneficiary per-month (PBPM) care management fees (CMFs) and at-risk PBPM performance-based incentive payments (PBIPs), which MDPCP Participants may use to fund investments in care management staff and activities not directly payable under the existing fee-for-service (FFS) payment system. The MDPCP also provides Track 2 MDPCP Participants a third payment stream of Comprehensive Primary Care Payments (CPCPs), which are intended to provide a more stable funding stream than the current FFS system. This enables MDPCP Participants to invest in the necessary care management and care coordination resources for care transformation.

MDPCP Track 3 builds on lessons learned from MDPCP Tracks 1 and 2 and CMS’s [PCF](#) Model, as well as stakeholder feedback from current MDPCP Participants and CTOs and the MDH. Track 3 further aligns with the goals of the Maryland TCOC Model to test whether population-based payments (PBPs), in conjunction with State-wide health care delivery transformation, improve population health and care outcomes for individuals, while controlling the growth of

Medicare TCOC. The goals of Track 3 include:

- (1) increase practice-level accountability for attributed MDPCP beneficiaries' costs and quality of care; and
- (2) move further from FFS to value-based payments by introducing a flat visit fee (FVF) for select primary care services paid at the time of service and a PBP that is paid prospectively on a quarterly basis.

Track 3 largely follows the policies of the PCF Model; however, it deviates slightly from the PCF Model given that this is a new track in a pre-existing program and is intended to be a glide path for MDPCP participants to assume greater accountability in later Performance Years of the MDPCP versus a stand-alone model such as the PCF Model. The MDPCP payments in Track 3 are expected to advance CMS' ongoing efforts to encourage participation in Advanced Alternative Payment Models (APMs). Beginning in Performance Year 2024, there will be two Tracks in the MDPCP: the Advanced Track (Track 2), and the Population-based Track (Track 3). The Standard Track (Track 1) will be phased out of MDPCP, effective January 1, 2024. Participant Practices are eligible to participate in Tracks 2 or 3. During Performance Year 2021, Participant FQHCs were eligible to participate only in Track 1; beginning in Performance Year 2022, Participant FQHCs also became eligible to participate in Track 2. We reiterate that FQHCs are not currently eligible to participate in Track 3

CMS is also accepting applications from a type of entity, a Care Transformation Organization (CTO). For purposes of the MDPCP, a CTO is defined as a legal entity that deploys an interdisciplinary care management team to furnish an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices, and performs other activities integral to helping Participant Practices to meet the applicable care transformation requirements under the MDPCP. The interdisciplinary care management team may furnish care coordination services such as: pharmacist services, health and nutrition counseling services, behavioral health specialist services, referrals and linkages to social services, and support from health educators and Community Health Workers (CHWs). The types of entities eligible to submit CTO applications may include health plans, Accountable Care Organizations (ACOs), managed service organizations (MSOs), Clinically Integrated Networks (CINs), hospitals, and other practice support organizations. A single organization may only submit one application type; that is, for example, a primary care practice may only apply to participate as a Participant Practice or a CTO.

A CTO selected to participate in the MDPCP will be paid by CMS for the care coordination services that the CTO's interdisciplinary care management team furnishes to Medicare beneficiaries attributed to each MDPCP Participant with which the CTO has partnered. While MDPCP Participants are not required to partner with a CTO, a CTO participating in the MDPCP is generally required to deploy an interdisciplinary care management team at the request of any MDPCP Participant that has elected to partner with the CTO under the MDPCP. This deployment facilitates beneficiary access to care management services that might be hard for the

MDPCP Participant to offer independently. In addition, a CTO facilitates an MDPCP Participant's care transformation by providing support for the improvement of the MDPCP Participant's process-of-care as part of the care coordination services furnished to the MDPCP Participant's attributed Medicare beneficiaries. CTOs are an important element of the MDPCP because they allow MDPCP Participants of all sizes to offer the types of specialized care management staff and processes to their attributed Medicare beneficiaries that can make a difference for those beneficiaries with chronic conditions.

I. Eligibility and Participation

The MDPCP is open to eligible primary care practices, FQHCs, and CTOs in the State. The CTO, primary care practice, and FQHC application period will begin on May 15, 2023, and end on July 17, 2023, at 11:59 PM ET. CMS will not accept applications to begin participation in the MDPCP in Performance Year 2024 that are submitted after July 17, 2023, at 11:59 PM ET. This is the final MDPCP RFA CMS intends to issue to solicit applications from primary care practices, FQHCs, and CTOs interested in participating in the MDPCP, including those that did not apply during a prior application period or that were not selected to participate in a prior Performance Year.

After the application period for Performance Year 2024 has concluded and CMS has selected eligible participants, the MDH will publish a list of the CTOs that have been selected to participate in the MDPCP, together with information regarding each geographic area in which the CTO will deploy its interdisciplinary care management team (hereinafter referred to as the CTO's "geographic coverage area"). CTOs will indicate their geographic coverage area, comprised of a county or counties in Maryland, in their application. As part of the application process, Applicant Practices and Applicant FQHCs will select whether to partner with a participating CTO. If the Applicant Practice or Applicant FQHC has selected to partner with a CTO, the Applicant Practice or Applicant FQHC may specify the CTO with which they wish to partner as part of the application process. Any CTO selections made as part of the application process are non-binding and Participant Practices and Participant FQHCs will have an opportunity to select new CTOs that may be participating in MDPCP for the first time in the 2024 Performance Year prior to the start of the 2024 Performance Year. MDH will send MDPCP Participants a final list of CMS-approved 2024 Performance Year CTO participants before the start of the Performance Year. While MDPCP Participants are not required to partner with a CTO, participating CTOs must partner with any Participant Practice or Participant FQHC that wishes to partner with them unless the CTO is unable to do so due to staffing limitations or because the Participant Practice or Participant FQHC is outside of the CTO's geographic coverage area. If a Participant Practice or Participant FQHC wishes to partner with a CTO that has reached capacity or for which the Participant Practice or Participant FQHC is outside the CTO's geographic coverage area, CMS will, if possible, assign the Participant Practice or Participant FQHC to the Participant Practice's or Participant FQHC's second CTO choice. If a CTO is at capacity due to staffing limitations, CMS will not require the CTO to partner with an

additional Participant Practice or Participant FQHC, nor will the CTO be required to expand its geographic coverage area.

Applicant Practices may also indicate a Track preference (Track 2 or Track 3); Applicant FQHCs may only participate in Track 2 in Performance Year 2024. CMS reserves the right to assign an Applicant Practice to a lower Track than their indicated preference based on CMS' assessment of the Applicant Practice's readiness to meet the applicable care transformation requirements. However, it is unlikely that CMS would assign an Applicant Practice to participate in a more advanced Track than their indicated preference. With the introduction of Track 3, timelines for an MDPCP Participant's transition to Track 3 were modified for new participants. Beginning in Performance Year 2024, Applicant Practices that select or are assigned to Track 2 may only remain in Track 2 for two Performance Years; if they wish to continue to participate in the MDPCP, they must transition to participate in Track 3 by no later than the beginning of their third Performance Year of participation in the MDPCP. For more information on Care Transformation Requirements in the different Tracks, see [Section II, Part A](#) of this RFA.

Practices, FQHCs, and CTOs that are accepted to participate in the MDPCP must sign a participation agreement with CMS in order to participate in the MDPCP. Each primary care practice, FQHC, and CTO accepted to participate in the MDPCP in response to this RFA will participate beginning on January 1, 2024 through the end of the final Performance Year of the MDPCP, which ends on December 31, 2026, unless their participation is terminated sooner.

CMS may offer MDPCP Participants and participating CTOs the opportunity to sign an amended and restated version of the participation agreement with CMS. If an MDPCP Participant or participating CTO fails to timely sign an amended and restated version of the participation agreement offered by CMS, CMS may terminate the MDPCP Participant or participating CTO's participation in the MDPCP.

A. Practice and FQHC Eligibility

Primary Care Practices

For purposes of the MDPCP, a primary care practice is a group of one or more physicians, non-physician practitioners, or combination thereof that furnishes certain specified primary care services, defined as the services described by the evaluation and management code set that is used to bill for office and outpatient visits under the Medicare Physician Fee Schedule, at a common location and bills for such services under a single Medicare-enrolled Taxpayer Identification Number (TIN). If the group is a legal entity that furnishes and bills for such primary care services at multiple locations (none of which is itself a legal entity), each location will be considered a separate primary care practice for purposes of the MDPCP. Thus, a legal entity that operates multiple such practice sites must submit a separate application for each practice site and, if selected to participate in the MDPCP, the MDPCP activities at each participating practice site will be governed by separate participation agreements executed by

CMS and the legal entity that operates those practice sites (“Practice Participation Agreement”). Each Applicant Practice must identify in its application:

- 1) A single practice site address, located in Maryland, at which the primary care practice and all of its participating practitioners would furnish the specified primary care services for purposes of the MDPCP; and
- 2) A single TIN under which the practice bills for purposes of the MDPCP.

In order for CMS to identify whether the practice is providing primary care services, the Applicant Practice must also include in its application a proposed roster of National Provider Identifiers (NPIs) of eligible practitioners who furnish certain primary care services at the practice site address included in the application and who wish to participate in the MDPCP (the “Practitioner Roster”). Primary care practitioners with a specialty code of General Practice (01), Family Medicine (08), Internal Medicine (11), Obstetrics and Gynecology (16), Pediatric Medicine (37), Geriatric Medicine (38), Nurse Practitioner (50), Clinical Nurse Specialist (89), Psychiatry (26), Preventive Medicine (84), Certified Nurse Midwife (42), and Physician Assistant (97) listed in the [National Plan and Provider Enumeration System](#) (NPPES) are eligible for inclusion on the Practitioner Roster. Practitioners identified with a specialty code of Psychiatry (26) must be co-located with an eligible practitioner with an eligible specialty code other than Psychiatry in order to participate in the MDPCP. All NPIs included on an applicant’s Practitioner Roster must practice at the single practice site address identified on the application; however, not all physicians or other practitioners that practice at that site must be included on the Applicant Practice’s Practitioner Roster. Those physicians or other practitioners at the practice site not included on the Applicant Practice’s Practitioner Roster would not participate in the MDPCP.

FQHCs

For purposes of the MDPCP, an FQHC is a legal entity identified by an organizational NPI, a CMS Certification Number (CCN) and a TIN, and is certified as an FQHC as defined under section 1861(aa) (4) of the Act. In the case of an FQHC that furnishes and bills for such FQHC services (as defined at section 1861(aa) (4) of the Act) at multiple locations (none of which is itself a separate legal entity), the FQHC may choose to apply to participate in the MDPCP either as one Participant FQHC, or as a separate Participant FQHCs for each of its locations. An FQHC that participates as one Participant FQHC must submit a single application that includes all of its FQHC sites located in Maryland and, if selected to participate in the MDPCP, would sign a single participation agreement with CMS to govern the MDPCP activities that occur at all such FQHC sites. If the FQHC elects for each of its locations to apply to participate as separate Participant FQHCs, the FQHC must submit a separate application for each such FQHC site and, if selected to participate in the MDPCP, the MDPCP activities at each participating FQHC site will be governed by separate participation agreements executed by CMS and the FQHC that operates those FQHC sites. Regardless of whether the participation agreement between CMS and

an FQHC governs the MDPCP activities at one FQHC site or at multiple FQHC sites, the participation agreement is referred to herein as an “FQHC Participation Agreement.”

Each Applicant FQHC must identify in its application the single organizational NPI under which the FQHC will bill for purposes of the MDPCP, the FQHC’s CCN, and its TIN so that CMS can determine whether the FQHC participates in an ACO under [the Medicare Shared Savings Program](#). An FQHC that submits a single application that includes all of its FQHC sites must identify in its application each of the addresses of the FQHC’s sites located in Maryland that furnish primary care services, defined as non-mental health G-codes which includes: FQHC new patient visit (G0466), FQHC established patient visit (G0467), and FQHC initial preventive physical exam (IPPE) or annual wellness visit (AWV). An FQHC that submits a separate application for each of its FQHC sites located in Maryland must identify in each such application the address at which the FQHC site furnishes the specified primary care services defined above. An Applicant FQHC is not required to submit a Practitioner Roster to CMS as part of its application.

General

In order to be eligible to participate in the MDPCP as an MDPCP Participant, an Applicant Practice or Applicant FQHC must meet the following criteria to the extent applicable to its applicant type:

1. For an Applicant Practice, the practice must use a single TIN, although not necessarily the same Medicare billing number, for billing all Primary Care Services furnished to MDPCP Beneficiaries by MDPCP Practitioners, and for receiving all MDPCP Payments from CMS;
2. For an Applicant Practice, all NPIs on the Applicant Practice’s Practitioner Roster must be enrolled in Medicare as reflected by an Approved status in the Provider Enrollment, Chain and Ownership System (PECOS)¹;
3. For an Applicant Practice, all NPIs on the Applicant Practice’s Practitioner Roster must submit Medicare FFS claims on a Medicare Physician/Supplier claim form (Form 837P or Form 1500) and be paid under the Medicare Physician Fee Schedule for office visits;
4. For an Applicant FQHC, the FQHC must submit claims and be paid under the FQHC Prospective Payment System (PPS) for FQHC services; and
5. The Applicant Practice or Applicant FQHC must maintain a minimum of 125 attributed Medicare FFS beneficiaries during each Performance Year, based on the

¹ PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information. More information as well as access to the PECOS system can be found on the PECOS website located [here](#).

attribution methodology described in [Section III, Part A](#) of this RFA;

6. The Applicant Practice or Applicant FQHC must meet additional requirements under the participation agreement entered into by the entity and CMS (the Practice Participation Agreement or FQHC Participation Agreement).

Applicants and Model participants will be subject to a program integrity screening. CMS may reject an application or terminate a Practice Participation Agreement or FQHC Participation Agreement on the basis of the results of a program integrity screening.

Program integrity screening activities help CMS detect and combat fraud, waste, and abuse of the Medicare and Medicaid programs. These activities use identifiers such as NPIs, CCNs, and TINs to cross-check applicants at a specific point in time across multiple systems to verify eligibility for MDPCP participation. Program integrity screening activities and systems include:

- Use of the PECOS to ensure applicants are enrolled as an active Medicare supplier or provider;
- Review of applicants' billing history to identify delinquent debt and any past or current reviews, audits, investigations, etc., for suspicious and fraudulent activity; and
- Research into any past civil or criminal actions related to behaviors or other factors relevant to participation in the MDPCP and the receipt of federal funds as an MDPCP Participant.

Adverse results from program integrity screening may relate to a variety of issues, including Medicare enrollment, Medicare billing privileges, outstanding Medicare debt, and current administrative review or investigation by CMS or other federal partners.

Primary Care Practice and FQHC Application Information

The MDPCP application for primary care practices and FQHCs is located [here](#) and will be open for application from May 15, 2023, through 11:59 PM ET on July 17, 2023.

To be considered for participation in the MDPCP, all primary care practice and FQHC applications must be completed using the online application. Click [here](#) to view a PDF version of the application questions for primary care practices and FQHCs for reference.

Primary Care Practices:

For Applicant Practices, the application must be submitted by the legal entity (e.g., group practice) that operates at the practice site address. If the legal entity operates at multiple practice sites, the legal entity must submit a separate application for each practice site address that it wishes to participate in the MDPCP.

For an Applicant Practice, the legal entity that operates at the practice site address must sign a Practice Participation Agreement with CMS as a condition of the practice site's participation in the MDPCP. If the same legal entity operates at multiple practice site addresses, it must sign a separate Practice Participation Agreement for each participating practice site address.

FQHCs:

For Applicant FQHCs, the FQHC must submit either a single application for all of its FQHC sites located in Maryland, or a separate application for each of its FQHC sites located in Maryland.

For an Applicant FQHC that submitted a single application for all of its FQHC sites located in Maryland, the FQHC must sign an FQHC Participation Agreement with CMS to govern MDPCP activities at all of its FQHC sites. For an Applicant FQHC that submitted a separate application for each of its FQHC sites located in Maryland, the FQHC must sign a separate FQHC Participation Agreement for each such FQHC site.

General:

All Applicant Practices and Applicant FQHCs must submit with their application a letter of support from a clinical leader within the primary care practice or FQHC demonstrating a commitment to the MDPCP and a willingness to provide leadership in support of the practice or FQHC's participation in the program. If the Applicant Practice or Applicant FQHC is owned by a person, entity, or organization other than a clinical or other leader who practices at the single primary care practice or FQHC location identified in the application, or by a separate entity or healthcare organization, the Applicant Practice and Applicant FQHC also must submit a letter of support from the owner committing to segregate funds that are paid based on the Applicant Practice or Applicant FQHC's participation in the MDPCP and assuring that all MDPCP payments will be used in a manner consistent with the Practice Participation Agreement or FQHC Participation Agreement, as applicable. Additionally, all Applicant Practices and Applicant FQHCs must submit a letter executed by both the Applicant Practice or Applicant FQHC and an authorized representative of a Health Information Exchange (HIE). The HIE must be capable of enabling the functions described herein, such as the [Chesapeake Regional Information System for our Patients](#) (CRISP). For an Applicant Practice or Applicant FQHC, this letter should indicate a commitment to achieving the aims of full connectivity by the start of the Applicant Practice's or Applicant FQHC's first year of participation as an MDPCP Participant.

Practices, FQHCs, and practitioners that currently participate in certain other CMS initiatives will be ineligible for concurrent participation in the MDPCP. Please reference [Section IV, Part C](#) of this RFA for additional information. Additionally, Rural Health Clinics and Critical Access Hospitals are not eligible to participate in the MDPCP. FQHCs are not eligible to participate in the MDPCP as Participant Practices, but are eligible to participate as a Participant FQHC.

Applicant Practices and Applicant FQHCs that meet the applicable eligibility requirements, successfully complete the application process, and meet the applicable care transformation requirements will be selected to participate in the MDPCP as an MDPCP Participant.

B. Care Transformation Organization Eligibility

CMS is accepting applications from CTOs, which are intended to support MDPCP Participants

in the MDPCP. CMS is accepting CTO applications from organizations such as ACOs, MSOs, health plans, CINs, hospitals, and other practice support organizations. The CTO applicant may be the CTO itself (a separate legal entity) or, if the CTO is an operating division of a legal entity, the legal entity that owns and operates the CTO.

In order to be eligible to participate in the MDPCP as a CTO, the organization must meet the following criteria:

1. The CTO must have the ability to support MDPCP Participants in performing the applicable care transformation requirements outlined in this RFA.
2. The CTO must meet additional requirements under the MDPCP CTO Participation Agreement (described in greater detail below).

CTOs and, if applicable, the organization that owns and operates the CTO, will be subject to a program integrity screening. CMS may reject an application or terminate a CTO Participation Agreement on the basis of the results of program integrity screening.

CTO Application Information

The MDPCP CTO application is located [here](#) and will be open for application from May 15, 2023, through 11:59 PM ET on July 17, 2023.

To be considered for participation in the MDPCP, all CTO applications must be completed using the online application. Click [here](#) to view a PDF version of the CTO application questions for reference. Organizations submitting a CTO application must submit a letter of support from the CTO's leadership (e.g., CEO or medical director) demonstrating a commitment to the MDPCP and a willingness to provide leadership in support of the CTO's participation in the program, as well as a letter of support from a primary care practice or FQHC.

To be considered an eligible CTO, a CTO applicant must demonstrate the ability to support MDPCP Participants in performing the applicable care transformation requirements outlined in this RFA. CTO applicants will be asked to describe the care management services that they propose to furnish to Medicare beneficiaries attributed to MDPCP Participants. CMS will assess CTO applications based on each organization's or, if applicable, the organization's owner's/operator's history and capability of providing care management services. CMS may choose to consider the breadth and depth of services each CTO proposes to offer to ensure that participating CTOs offer a wide variety of services, as well as the organization's location to ensure that CTOs are geographically dispersed throughout the state of Maryland.

Applicants that meet CTO eligibility requirements and successfully complete the CTO application process will be selected to participate in the MDPCP as a participating CTO ("CTO Participant"). Selected CTOs or if the CTO is owned by another healthcare organization, the parent organization, must sign a participation agreement with CMS (the "CTO Participation Agreement") as a condition of participation in the MDPCP. The CTO Participation Agreement will outline certain governance requirements for the CTO, including representation by the

MDPCP Participant(s) that have partnered with the CTO under the MDPCP on the CTO's governing body. CTOs will be given appropriate time to establish representation from partner MDPCP Participants on the CTO's governing body once they are partnered with their MDPCP Participants. CTO Participants will also have financial accountability for quality and utilization metrics for the Medicare beneficiaries attributed to the primary care practices and FQHCs with which they are partnered under the program.

C. Multi-Payer Strategy

In an effort to improve population health and reduce overall health care costs, CMS plans to enter in to one or more [Memoranda of Understanding \(“MOU”\)](#) with payers who are also interested in supporting comprehensive primary care reform within MDPCP Participants in Maryland. In Fall 2019, CMS solicited proposals from third-party payers operating in Maryland who were interested in aligning with the principles of advanced primary care in the MDPCP. CareFirst submitted a proposal in response to this solicitation, was selected by CMS, and on January 1, 2020, CMS entered into an MOU with CareFirst as an aligned payer. Maryland's Medicaid managed care program, HealthChoice, also submitted a proposal in response to this 2019 solicitation and continues to engage with CMS to finalize their proposal.

MDPCP Participants may enter into arrangements with participating payers for additional support in delivering advanced primary care. Entering into such arrangements is at the discretion of the MDPCP Participants and payers; MDPCP Participants are not required to enter into arrangements with payers other than CMS under the terms of the applicable MDPCP participation agreement.

Payer Solicitation Information

On May 11, 2021, CMS issued a [solicitation](#) for additional payers interested in aligning with the principles of advanced primary care in the MDPCP, with proposals due annually by 11:59 PM ET on November 1 prior to the Performance Year in which they seek to participate. CMS may issue a solicitation for additional payers interested in aligning with the MDPCP in spring 2023 for payers interested in joining the Model in Performance Year 2024. The solicitation outlines a framework for payers to indicate steps they are taking to support the provision of advanced primary care in Maryland that align with CMS' efforts in the MDPCP. The solicitation asks payers to provide a description of how their strategy is consistent with the principles of the MDPCP described below.

CMS will enter into MOUs with payers that timely submit proposals in response to the payer solicitation, provided such proposals demonstrate with specificity that the payer's approaches to support MDPCP Participants in delivering advanced primary care are consistent with the principles of the MDPCP described below. The purpose of the MOU is to memorialize each party's respective commitments to the goals of the MDPCP. CMS will assess payer proposals to determine the extent of their alignment with the following principles:

Financial Incentives

- Provide an enhanced claims or non-claims based payments, similar to the Care Management Fee (CMF), to support partner MDPCP Participants in providing care not traditionally covered as billable office-based services, such as non-visit-based care or enhanced behavioral health services.
- Provide an at-risk performance-based incentive payment, similar to the Performance Based Incentive Payment (PBIP), that encourages accountability of partner MDPCP Participants based on performance on certain quality and utilization metrics specified in the payer solicitation.
- Provide a partially capitated payment, similar to the CPCP, to advanced partner MDPCP Participants to create a more predictable revenue stream and reduce dependence of partner MDPCP Participants on visit-based care for revenue.²

Care Management

- Incentivize MDPCP Participants to target high-risk, high-need members and to ensure these members receive longitudinal care management to reduce potentially avoidable utilization.

Quality Measures

- Require partner MDPCP Participants to report certain quality measures to the payer that are the same or similar to the electronic clinical quality measures (eCQMs) that CMS requires MDPCP Participants to report to CMS in the MDPCP.

Data Sharing

- Share aggregate (patient de-identified) cost and utilization data on members attributed to (or seen by) a payers' partner MDPCP Participants with CMS for monitoring and evaluation purposes.
- Offer partner MDPCP Participants the opportunity to request member-level cost and utilization data to facilitate care management and follow-up for chronic and acute conditions in accordance with applicable law.

Practice Learning

- Participate in the MDPCP Learning Network and/or provide learning resources to support partner MDPCP Participants in performing the Comprehensive Primary Care Functions

² Without State legislative changes, MDPCP participating payers are unable to align with Track 3's financial structure. Aligned payers will continue to align with MDPCP Tracks 1 and 2 unless or until State legislative changes are made.

of Advanced Primary Care.

D. Selection of MDPCP Participants and CTO Participants

Applicant Practices, Applicant FQHCs, and Applicant CTOs should apply online and are required to answer all of the questions in their respective online application. The CTO application may be found at <https://app.innovation.cms.gov/mdpcp> and the application for primary care practices and FQHCs can be found at <https://app.innovation.cms.gov/mdprov>.

CMS will assess each application to verify that the applicant meets the applicable eligibility requirements and can meet the applicable care transformation requirements. All Applicant Practices, Applicant FQHCs, and Applicant CTOs will be subject to a program integrity screening, which includes, if applicable, an assessment of the applicant's current status in the Medicare program by CMS' Center for Program Integrity. Additionally, applicants must disclose any sanctions, investigations, probations, actions or corrective action plans to which its practitioners, owners or managers, and/or other participating organizations, entities, or individuals are currently subject or have been subject at any point during the last five years.

Given that CMS is testing primary care transformation across the entire State, CMS will accept into the MDPCP all Applicant Practices and Applicant FQHCs that meet the applicable eligibility requirements and that CMS determines can meet the applicable care transformation requirements based on the contents of their application.

As part of their application, Applicant Practices and Applicant FQHCs may identify the CTO with which they would like to partner, if any. The CTO selection that an Applicant Practice or Applicant FQHC makes in its application is non-binding, as Participant Practices and Participant FQHCs will have an opportunity to select new CTOs that may be participating in the MDPCP for the first time in the 2024 Performance Year. Primary care practices, FQHCs, and CTOs that submit applications during the 2023 application period, that are selected to participate in the MDPCP, and that sign a Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement with CMS (as applicable) are expected to begin participation in the MDPCP in January 2024. The application itself is not a legally binding contract and does not require any applicant to sign a participation agreement with CMS, if selected.

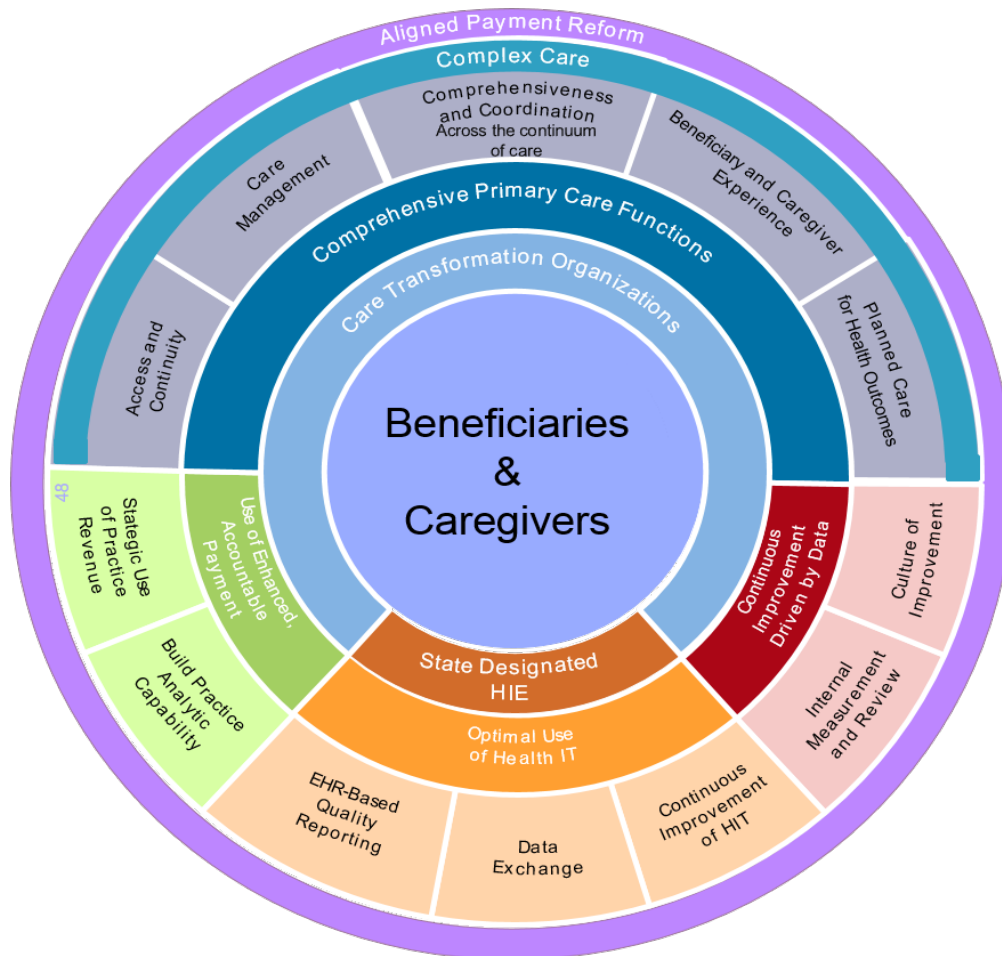
All determinations about whether to accept a primary care practice, FQHC, or a CTO for participation in the MDPCP will be made by CMS at CMS' sole discretion and will not be subject to any administrative or judicial review, per section 1115A(d)(2) of the Act.

II. Theory of Care Transformation

By requiring MDPCP Participants to meet specific care transformation requirements and aligning Medicare payments accordingly, CMS and the State expect that MDPCP Participants will provide more comprehensive and continuous care. This will likely reduce beneficiaries' complications and overutilization of services in higher cost settings, which in turn should lead to better quality and lower costs of care. An outline of the theory of action for all Tracks in the

MDPCP and the broad overview of the initiative is visually represented by the driver diagram in Figure 1.

Figure 1. MDPCP Driver Diagram



The care delivery redesign that CMS and the State believe is necessary to produce the desired outcomes is the same across all Tracks of the MDPCP. Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care (the top half of the radial diagram, shown in light blue and grey above) is based upon principles akin to those that underpin CMS' other comprehensive primary care models. The underlying practice structures and processes required for practices to deliver these functions (shown in the lower half of the radial diagram above) are found in Driver 2: Use of Enhanced, Accountable Payment (shown in green), Driver 3: Continuous Improvement Driven by Data (shown in burgundy), and Driver 4: Optimal Use of Health IT (shown in orange) supported by connectivity to a HIE capable of carrying out the functions described herein. MDPCP Participants will be required to redesign the care they furnish to perform the five Comprehensive Primary Care Functions of Advanced Primary Care as an ongoing participation requirement in the MDPCP.

A. Practice Care Transformation Requirements

While all Tracks of the MDPCP require MDPCP Participants to redesign the care they furnish in order to perform the same five Comprehensive Primary Care Functions of Advanced Primary Care, the intensity and scope of the underlying care transformation requirements differs from Track to Track. MDPCP Participants in all Tracks will be asked to redesign primary care delivery with a focus on care management of all attributed patients and an increasing focus on value-based care that expands care delivery beyond the FFS environment of the office. More information on specific care transformation requirements for each Track will be provided by CMS in the CMS MDPCP Participation Agreements.

CMS will require MDPCP Participants to perform primary care functions using a framework of care transformation requirements, which gradually increases in scope and intensity over the duration of the MDPCP with markers for regular, measurable progress towards the necessary capabilities. MDPCP Participants will report their progress on the care transformation requirements regularly by responding to surveys through a secure web portal (the MDPCP Portal). CMS will support MDPCP Participants by making feedback reports available to use in care coordination, internal quality assessment, and care improvement activities.

The MDPCP includes certain changes to the Medicare FFS payment systems to help support Participant Practices in their efforts to meet the applicable care transformation requirements. (See [Section III.B. Payment to Participant Practices](#) of this RFA for more information.)

Beginning in Performance Year 2022, CMS began making a Health Equity Advancement Resource and Transformation (HEART) payment to MDPCP Participants to provide additional support for participants serving socioeconomically disadvantaged populations. The HEART payment promotes the State's and CMS' goal to improve health equity. CTO Participants will also be available to provide care coordination services to beneficiaries attributed to partner MDPCP Participants. Under the MDPCP, CMS and MDH also provide a Learning Network to help MDPCP Participants become accustomed to furnishing advanced primary care. (See [Section IVA. The MDPCP Learning Network](#) of this RFA for more information on the MDPCP Learning Network.)

Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care

The five Comprehensive Primary Care Functions of Advanced Primary Care described below serve as the primary drivers towards achieving the aims of the MDPCP. These functions represent a transformation towards the beneficiary-centered and team-based care delivered in the right place, at the right time, and in a manner that empowers beneficiaries. Below is a summary of each of the primary drivers as related to the care transformation requirements. For more detail on the specific practice care transformation requirements themselves please refer to the MDPCP participation agreements.

Access and Continuity

Effective primary care is built on the relationship between a beneficiary, his or her caregivers, and the team of professionals who provide care for the beneficiary. The foundation is a trusting, continuous relationship between beneficiaries, their caregivers, and the professionals who provide care management. Empanelment is a key ingredient in support of team-based care. Empanelment enables an MDPCP Participant to determine whether each practitioner and team has a reasonable balance between an attributed beneficiary's demand for care and the capacity to provide that care. MDPCP Participants in all Tracks must empanel (or assign) all attributed beneficiaries so that every beneficiary has the opportunity to build a therapeutic relationship, and that the practitioner and care team understand their population of attributed beneficiaries.

A CTO's interdisciplinary care management team must, at the partner MDPCP Participant's request, assist partner MDPCP Participants in meeting the care transformation requirements by providing care coordination services under the supervision of the attributed beneficiary's health care provider who practices at a partner MDPCP Participant. These care coordination services may be furnished at the MDPCP Participant's location or in the community, as appropriate.

Care Management

MDPCP Participants are required to provide care management for high-risk, high-need, and rising risk beneficiaries by integrating a care manager into practice operations. MDPCP Participants must risk stratify all empaneled beneficiaries and provide both longitudinal, relationship-based care management as well as episodic, goal-directed care management as appropriate to best improve outcomes for empaneled beneficiaries. To that end, all MDPCP Participants will be required to maintain resources to provide care management to at least 5% of their attributed Medicare beneficiaries. To guide their care management efforts, MDPCP Participants will be required to create care plans focused on goals and strategies congruent with beneficiaries' choices and values.

CTOs must support their partner MDPCP Participants as part of the care coordination services provided to Medicare beneficiaries attributed to those MDPCP Participants.

Comprehensiveness and Coordination across the Continuum of Care

MDPCP Participants play an important role in helping attributed beneficiaries and caregivers navigate and coordinate care and services. Primary care practices and FQHCs often serve as the hub through which other health care providers coordinate care.

Comprehensive care will differ based on a beneficiary's needs. In order to meet the care transformation requirements, MDPCP Participants must use data to identify the hospitals and emergency departments (EDs) responsible for attributed beneficiaries' hospitalizations and ED visits in order to improve the timeliness of notification and information transfer. MDPCP Participants must also systematically identify high-volume and/or high-cost specialists serving the beneficiary population using data. MDPCP Participants in Track 2 and Track 3 will be

required to strengthen their referral and/or co-management relationships with specialists and community and social services, ensuring comprehensiveness of service availability for their beneficiaries. MDPCP Participants must build capabilities to deliver and integrate behavioral health into care.

All MDPCP Participants must know where in the medical neighborhood their attributed beneficiaries receive care and should coordinate beneficiary care accordingly. MDPCP Participants in Track 2 and Track 3 will be required to complete an assessment of their attributed beneficiaries' health-related social needs and to conduct an inventory of resources and supports in the community to meet those needs. For purposes of this systematic assessment, Track 2 and Track 3 MDPCP Participants must utilize a health-related social needs screening tool.

MDPCP Participants must address opportunities to improve transitions of care for attributed beneficiaries, focusing on hospital and ED discharges, as well as post-acute care facility usage and interactions with specialists. Such a transformation will be an ongoing process.

In furnishing care coordination services to attributed beneficiaries, CTO Participants must, at the partner MDPCP Participant's request, assist in analyzing where beneficiaries receive care and how best to coordinate that care in the way that achieves the best outcomes. The care coordination services furnished by a partner CTO's interdisciplinary care management team must assist partner MDPCP Participants in meeting the care transformation requirements, at the MDPCP Participant's request.

Beneficiary and Caregiver Experience

Even with the most proactive care service provision, beneficiaries and caregivers maintain a critical role in ensuring optimal care delivery. MDPCP Participants in all Tracks will be required to engage attributed beneficiaries and caregivers in designing and improving care processes using a Patient-Family/Caregiver Advisory Council (PFAC) and other similar strategies to incorporate beneficiary needs and preferences into their care redesign plans. To increase beneficiary engagement, the PFAC will work alongside MDPCP Participants to engage attributed beneficiaries in goal-setting and shared decision-making.

Planned Care for Health Outcomes

MDPCP Participants in all Tracks will be required to develop an understanding of their attributed beneficiary populations and to respond to those needs accordingly, including to proactively offer timely and appropriate preventive care and reliable, evidence-based management of chronic conditions.

MDPCP Participants must develop and stage interventions to engage attributed beneficiaries *before* they require hospitalization. To successfully prevent avoidable hospitalizations, MDPCP Participants may leverage disease registries, staff such as health coaches and educators (including CHWs), and partnerships with the non-clinical community—all of which can help identify and address gaps in care for at-risk beneficiaries. MDPCP Participants must apply

evidence-based protocols for screening, diagnosis, and treatment. Finally, MDPCP Participants will have the opportunity to request data and reports from CMS Center for Medicare and Medicaid Innovation (the Innovation Center) and State data systems, in accordance with applicable law, and use the MDPCP Participant's own data to gain a full view of their attributed beneficiaries' utilization of services, quality of care, and total cost of care, to help identify performance improvement opportunities. The State will work to enhance the data Participant Practices receive for planned care and population health.

Driver 2: Use of Enhanced, Accountable Payment

The five Comprehensive Primary Care Functions of Advanced Primary Care collectively serve as a primary driver toward achieving the aims of the MDPCP, but these changes in patterns of care require a corresponding change in payment. The MDPCP redesigns the Medicare FFS payments made to MDPCP Participants and CTO Participants to help them perform care transformation activities and deliver the Comprehensive Primary Care Functions of Advanced Primary Care. Specifically, CMS distributes CMFs to the MDPCP Participants and CTO Participants. CMFs can only be used as specified in the MDPCP Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement to meet the care transformation requirements. MDPCP Participants will be required to report to CMS actual expenditures of the CMF and ratios of such expenditures to total primary care practice or FQHC income.

CMS also distributes at-risk performance payments to both the MDPCP Participants and CTO Participants to increase accountability for meeting the goals of the MDPCP. CMS distributes quarterly prospective payments to MDPCP Participants in Track 2 in the form of a CPCP, which replaces a percentage of the MDPCP Participant's practitioners Medicare FFS payments during the Performance Year. MDPCP Participants in Track 3 will receive a population-based payment (PBP), a flat visit fee (FVF) payment, a HEART payment, and a performance-based adjustment (PBA) to incentivize performance on certain utilization and efficiency measures.

Driver 3: Continuous Improvement Driven by Data

Participant Practices in all Tracks of the MDPCP will be required to reliably and systematically measure quality and utilization at the MDPCP Participant level. If the MDPCP Participant is an FQHC that has signed a single FQHC Participation Agreement for all of its FQHC sites, the Participant FQHC also needs to collect this information at the FQHC site level. MDPCP Participants are generally expected to use the captured quality and utilization data to test and implement new workflows and to identify opportunities for continued improvement. Statewide performance dashboard tools will be made available to MDPCP Participants and CTO Participants by CMS.

Driver 4: Optimal Use of Health IT

In all Tracks, MDPCP Participants will be required to use Certified EHR technology (CEHRT) in accordance with the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable, to ensure remote access to each attributed beneficiary's EHR for the MDPCP Participant's care team members. MDPCP Participants in all Tracks must report on eQMs and generate quality reports, in accordance with the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable. If the MDPCP Participant is an FQHC that has signed a single FQHC Participation Agreement for all of its FQHC sites, the Participant FQHC also needs to collect this information at the FQHC site level.

To be eligible to participate in the MDPCP, an Applicant Practice or Applicant FQHC must submit a letter executed by both the primary care practice or FQHC and an HIE representative certifying the applicant's commitment to achieving the aims of full connectivity by the start of its first year as an MDPCP Participant. For the purposes of the MDPCP, full connectivity is defined as the ability to send and receive clinical information about a practice's or FQHC's attributed beneficiaries to and from the HIE. This will increase and enhance the comprehensiveness of beneficiary data available to the health care providers who treat the attributed beneficiary. Each MDPCP Participant will be expected to consider the Health Insurance Portability and Accountability Act of 1996 (HIPAA)³ requirements applicable to this arrangement, including the need to enter into a business associate agreement with its HIE, and to share clinically meaningful data across the delivery system as permitted by applicable law.

B. The CTO's Role in the MDPCP

The five Comprehensive Primary Care Functions of Advanced Primary Care require MDPCP Participants to become a hub for the coordination and management of their attributed beneficiaries' care across the delivery system. In the MDPCP, CTOs will be available to furnish care coordination services to Medicare beneficiaries attributed to partner MDPCP Participants, helping these MDPCP Participants meet the care transformation requirements under the MDPCP.

CTO Participants can leverage economies of scale and deploy resources that would be difficult or uneconomical for a partner MDPCP Participant to deploy by itself. CMS will make payments of the CMF and PBIP directly to the CTO for care coordination services furnished by the CTO to attributed Medicare beneficiaries of partner MDPCP Participants performed to assist the partner MDPCP Participant in meeting the applicable care transformation requirements. These payments are described in detail in [Section III, Part B](#) of this RFA. CTOs must spend CMF payments received from CMS under the MDPCP on care management professionals and support staff who perform each of the five activities described in further detail in this RFA and the CTO Participation Agreement.

CTO activities are designed to help partner MDPCP Participants achieve the MDPCP's care

³ Public Law 104–191, 110 Stat. 1936

transformation requirements. CTOs may not spend payments received from CMS under the MDPCP for performing care coordination or other services independent of the MDPCP Participants with which they are partnered under the program, nor to provide care coordination services to patients other than Medicare beneficiaries attributed to their partner MDPCP Participants. Further, CTOs are designed to help MDPCP Participants advance primary care under the MDPCP and not to support general practice operations such as billing, coding, or clinical work unrelated to the MDPCP. Therefore, CTOs are required to assist partner MDPCP Participants solely in meeting the applicable care transformation requirements.

The following section describes a menu of the range of CTO activities integral to helping partner MDPCP Participants meet the MDPCP's care transformation requirements. (More information about CMFs and PBIPs can be found in [Section III, Part B](#) of this RFA.)

Activity 1: Care Coordination Services

A CTO Participant's care management staff may furnish care coordination services to Medicare beneficiaries attributed to partner MDPCP Participants. As part of meeting the care transformation requirements, an MDPCP Participant's attributed beneficiaries must be empaneled to a primary care practitioner who is a member of the MDPCP Participant and, for an MDPCP Participant that is a Participant Practice, is listed on the practice's Practitioner Roster (or to a care team of such practitioners). All care management staff deployed by the CTO are expected to provide services to the partner MDPCP Participant's attributed beneficiaries under the supervision of a primary care practitioner of the MDPCP Participant (in the case of an empaneled beneficiary, to the practitioner to whom the beneficiary has been empaneled). CTO Participants are not permitted to furnish care coordination services to Medicare beneficiaries attributed to partner MDPCP Participants under the MDPCP without the involvement of the MDPCP Participant's primary care practitioners.

The CTO must employ and manage an interdisciplinary care management team of health care providers, which may include nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (such as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants. MDPCP Participants may find that they lack the scale to economically deploy a full interdisciplinary care management team of this nature.⁴ Thus, a CTO may share its care management staff across multiple MDPCP Participants, so that a full interdisciplinary care management team can economically furnish care management services to a greater number of Medicare beneficiaries attributed to each of the CTO's partner MDPCP Participants.

⁴ Peikes, D. N., Reid, R. J., Day, T. J., Cornwell, D. D., Dale, S. B., Baron, R. J., ... & Shapiro, R. J. (2014). Staffing patterns of primary care practices in the comprehensive primary care initiative. *The Annals of Family Medicine*, 12(2), 142-149. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3948761/>

Activity 2: Support for Care Transitions

A CTO Participant's interdisciplinary care management team must, upon request by the partner MDPCP Participant, provide support to attributed Medicare beneficiaries for periods of transitions in care and for 24-hour care management outside of the partner MDPCP Participant's physical office. Regardless of where the interdisciplinary care management team furnishes care coordination services to attributed Medicare beneficiaries, the interdisciplinary care management team is expected to coordinate with the partner MDPCP Participant's primary care practitioners by email and telephone and to operate under the practitioners' direction and control.

The increased emphasis on care management and coordination that occurs during transitions of care will extend the partner MDPCP Participant's ability to provide care coordination services, including onsite visits at a hospital, nursing home, or other institutional settings. CTOs must also, at the partner MDPCP Participant's request, assist in systematically identifying high-volume and/or high-cost specialists serving the attributed beneficiary population and develop common discharge and medication management plans to ensure that post-discharge care includes plans for practice-based care and medication management.

Activity 3: Standardized Beneficiary Screening

As required to meet the care transformation requirements related to the Comprehensiveness and Coordination across the Continuum of Care Comprehensive Primary Care Function of Advanced Primary Care, all MDPCP Participants must risk-stratify their empaneled beneficiaries and each beneficiary attributed to a Track 2 or Track 3 MDPCP Participant must receive a standardized screening for health-related social needs using a health-related social needs screening tool.⁵ Risk stratification and standardized screening will help to identify the need to refer beneficiaries to social service organizations, community-based organizations, and public health agencies. The CTO's interdisciplinary care management team may assist in performing this risk stratification and screening and may also refer attributed Medicare beneficiaries to community social service organizations, at the direction of a practitioner from the partner MDPCP Participant.

Activity 4: Data Tools and Informatics

To participate in this program, MDPCP Participants must use CRISP or a similar product from another HIE that is capable of communicating with CRISP in accordance with the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable, to ensure remote access to an attributed beneficiary's EHR for care team members, including those deployed by the CTO. The CTO will offer partner MDPCP Participants assistance in utilizing the common data and health IT systems in order to promote effective strategies for treatment planning and monitoring health outcomes between different health care providers and across multiple settings of care. We expect that this will lead to reductions in unnecessary resource use

⁵ Billioux et al., 2017.

by avoiding duplication of services. Each partner MDPCP Participant will be expected to consider the HIPAA requirements applicable to this arrangement, including the need to enter into a business associate agreement with its partner CTO and HIE, and to share clinically meaningful data across the delivery system as permitted by applicable law.

Activity 5: Practice Transformation Assistance

CTO Participants must assist partner MDPCP Participants in meeting the applicable care transformation requirements in order to advance primary care delivery within their primary care practice. A CTO may assist partner MDPCP Participant with workflow changes that could allow improved integration with care managers and other team members. CTOs will be available to provide care coordination services to Medicare beneficiaries attributed to partner MDPCP Participants and deploy resources in order to help these MDPCP Participants meet the applicable care transformation requirements under the MDPCP.

III. Enhanced Financial Support and Accountability for Practices

CMS will support MDPCP Participants in performing the five Comprehensive Primary Care Functions of Advanced Primary Care through a series of payments that diverge from those made under the Medicare Physician Fee Schedule and FQHC PPS. Each MDPCP Participant participating in Track 2 will receive two payments—the CMF and the at-risk PBIP. The amount of these two payments is based on the number of Medicare beneficiaries attributed to that MDPCP Participant and certain other factors. Since Performance Year 2022, CMS has also provided a HEART payment as part of the CMF to provide additional support to MDPCP Participants serving socioeconomically disadvantaged populations in order to promote the state’s and CMS’ goal to improve health equity. For Track 2 MDPCP Participants, the MDPCP also involves a hybrid payment that includes an increasing proportion of partially capitated payments. For Track 3 Participant Practices, the MDPCP includes three distinct payments: (1) a FVF paid at the time of services; (2) a PBP paid prospectively on a quarterly basis; and (3) a HEART payment also paid prospectively on a quarterly basis. CMS expects that the Track 2- and Track 3-specific payments will allow MDPCP Participants in Track 2 and Participant Practices in Track 3 greater flexibility to target their efforts towards those beneficiaries who exhibit the greatest need for care coordination services.

A. Attribution of Beneficiaries

CMS will use an attribution methodology to identify the beneficiaries expected to be served by a MDPCP Participant. CMS will use Medicare claims filed during a 24-month lookback period to determine the MDPCP Participant to which beneficiaries will be attributed. Dual eligible beneficiaries who are enrolled in a Medicaid Health Home are excluded from MDPCP attribution and will not be attributed to an MDPCP Participant for purposes of the MDPCP.

Each MDPCP Participant will be responsible for the care management of the beneficiaries on its

attribution list. CMS will make the attribution lists available to MDPCP Participants on a quarterly basis during each Performance Year. CMS will provide MDPCP Participants with the MDPCP 2024 Payment Methodology document at or before the start of the 2024 Performance Year. The MDPCP Payment Methodology documents will provide further detail on the attribution and payment structure outlined in the Practice Participation Agreement and FQHC Participation Agreement and will be updated annually.

The attribution methodology is the same for all MDPCP Participants, regardless of the track in which they are participating.

B. Payments to Participant Practices

CMS will distribute MDPCP payments to MDPCP Participant Practices based on the MDPCP Participant's number of attributed beneficiaries, performance, Track, and other factors. Track 2 payments include CMF, HEART (part of CMF), PBIP, and Comprehensive Primary Care Payments. Track 3 includes a PBP, FVF, and a HEART payment.

Track 2 Payments

1. Care Management Fees (CMFs)

CMS will pay Participant Practices in Track 2 a CMF for attributed Medicare FFS beneficiaries on a per beneficiary per member (PBPM) basis; attributed beneficiaries will not be required to pay cost-sharing on the CMF. Given the similarity between the care transformation requirements under the MDPCP and Chronic Care Management (CCM) services covered by Medicare FFS, MDPCP Participants in Track 2 will not be permitted to bill Medicare for CCM services furnished to attributed Medicare beneficiaries.

Table 1 illustrates the CMF amounts and beneficiary risk tiers for the 2024 Performance Year. The CMF payment amount varies across the beneficiary risk tiers to reflect the increased resources required to target care management to attributed beneficiaries with more complex medical needs. Beneficiary risk will generally be based on CMS' hierarchical condition category (HCC) risk scores and claims data for diagnoses. Risk-tier cutoffs will be determined using a regional pool of Medicare FFS beneficiaries. There will be five beneficiary risk tiers, which includes a "Complex" tier for attributed beneficiaries either in the top 10% of HCC risk scores or with dementia. The update to the CMS-HCC model to Version 24, which includes persistent and severe mental illness and substance use disorder, eliminated the need to place MDPCP beneficiaries with those diagnoses into the Complex tier automatically.

Beginning in Performance Year 2022, the CMF also includes a HEART payment, which provides additional support to MDPCP Participants serving socioeconomically disadvantaged populations in order to promote the State's and CMS' goal to improve health equity. HEART payments will be based on Area Deprivation Index ([ADI](#)), a validated composite measure based on publicly-available US census data (2011–2015) for Maryland census block groups that

quantifies neighborhood socioeconomic disadvantage, and CMS-HCC clinical risk data. When combined with CMS-HCC clinical risk data, ADI has been demonstrated to improve identification of high-need Medicare beneficiaries.⁶ The HEART payment is \$110, paid on a PBPM basis for all attributed beneficiaries in the highest ADI quintile of for MDPCP beneficiaries and who fall into the 4th or Complex CMS-HCC risk tiers. During Performance Year 2024, the HEART payments are added to the CMF payment amounts shown in *Table 1: Care Management Fee Amounts for 2024 Performance Year*.

Table 1. Care Management Fee Amounts for the 2024 Performance Year

	Track 2	
Risk Tier	Criteria	PBPM CMF
Tier 1	01-24% HCC	\$9
Tier 2	25-49% HCC	\$11
Tier 3	50-74% HCC	\$19
Tier 4	75-89% HCC	\$33
Complex	90+% HCC or dementia	\$100

MDPCP Participants will receive significantly higher CMF payments from CMS for attributed beneficiaries who fall into the Complex risk tier to support the enhanced services required for beneficiaries with complex medical needs, who often also have high medical costs. Track 2 MDPCP Participants will receive a \$100 PBPM CMF to reflect the complexity of care management for these beneficiaries. CMS will assign beneficiaries to the Complex risk tier who fall within the top 10% of the HCC scores, as well as beneficiaries who, according to Medicare claims, have dementia.

The CMF must be used to perform activities related to meeting the MDPCP’s care transformation requirements (e.g., supporting and augmenting staffing, performing training, and supporting the care management of attributed Medicare beneficiaries). MDPCP Participants will decide how, specifically, to invest these payments based on their own clinical expertise, provided that they adhere to the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable, including the obligation to comply with all fraud and abuse and other applicable laws. The HEART portion of the CMF may be used to pay for enhanced care management services and related activities to improve outcomes and address the relatively high cost of care for MDPCP Beneficiaries at highest risk for poor health outcomes and health-related

⁶ Sapra KJ, YangW, Walczak, NB, Cha, SS. Identifying High-Cost Medicare Beneficiaries: Impact of Neighborhood Socioeconomic Disadvantage. *Pop Health Mgmt.* 2020;23(1):12-19. <https://doi.org/10.1089/pop.2019.0016>.

social needs.

CMS will monitor the use of CMF payments through the MDPCP Participants' submission of actual CMF expenditures and spending ratios. CMS will also monitor MDPCP Participants' coding and HCC score changes closely throughout the duration of the MDPCP. If significant, unexpected, or irregular up-coding or changes in HCC scores are found to occur, CMS will adjust the CMF payment methodology in order to ensure the actuarial soundness of the MDPCP. CMS may also take remedial action against MDPCP Participants in accordance with the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable.

The CMF amount may be adjusted by CMS to enable the State to meet the Annual Savings Target in the Maryland Total Cost of Care Model Agreement.⁷ In accordance with the terms of the Practice Participation Agreement and FQHC Participation Agreement, CMS may revise the CMF payment amounts over the course of the MDPCP. In the event that CMS decides to make changes to the CMF payment methodology and/or adjust CMFs, CMS will notify MDPCP Participants of such changes prior to the quarter in which they take effect.

2. Performance-Based Incentive Payments (PBIPs)

To encourage and reward accountability for beneficiary experience, clinical quality, and utilization measures that drive total cost of care, Track 2 of the MDPCP will include a prepaid PBIP. CMS will pay the annual PBIP prospectively, but an MDPCP Participant may retain the PBIP (in whole or in part) only if it meets certain annual performance thresholds. Thus, an MDPCP Participant will be required to repay any part or all of its PBIP depending on its performance. In accordance with applicable debt collection regulations, CMS may collect any PBIP owed by an MDPCP Participant by reducing payments that would otherwise be made to the MDPCP Participant, including ongoing Medicare FFS payments.

The PBIP is broken into distinct components, all paid prospectively:

- (1) Incentives for performance on clinical quality/patient experience measures;
- (2) Incentives for performance on certain utilization measures selected by CMS on the grounds that they drive total cost of care; and
- (3) Incentives for performance on an efficiency measure, Total Per Capita Cost (TPCC).

MDPCP Participants will receive upfront PBIPs in Track 2, as outlined in *Table 2*. MDPCP Participants may retain all or a portion of these amounts, depending on their performance on the clinical quality/patient experience and utilization components, as described in more detail in this section of the RFA. The final calculation methodology will be outlined in the Practice Participation Agreement and FQHC Participation Agreement so that Applicant Practices and Applicant FQHCs more fully understand the payment mechanism prior to the start of their participation in the MDPCP.

⁷ <https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>

Table 2. Performance Year 2024 Practice/FQHC Performance-Based Incentive Payment Amounts by Track, Per Beneficiary, Per Month (PBPM)

Track	Utilization and Efficiency (PBPM)	Quality (PBPM)	Total (PBPM)
Track 2	\$2.00	\$2.00	\$4.00

CMS will make a single, annual PBIP to each MDPCP Participant based on the beneficiary attribution list described in [Section III, Part A](#) of this RFA for the first calendar quarter of the Performance Year. This payment includes the clinical quality/patient experience and utilization components. In order to be eligible to retain any portion of the PBIP, the MDPCP Participant must successfully and completely report on the required eQMs by the end of each Performance Year, as specified in the Practice Participation Agreement or FQHC Participation Agreement, as applicable.

The amount of the PBIP retained by an MDPCP Participant at the end of each Performance Year will be based on the MDPCP Participant’s performance on the clinical quality/patient experience, utilization, and efficiency measures for Track 2 MDPCP Participants. CMS will score such performance using a continuous approach. MDPCP Participants with a score below 50% keep none of the PBIP amount. MDPCP Participants with a score of 80% or higher keep the entire PBIP amount. A 60% score, for example, results in the MDPCP Participant keeping 60% of its PBIP. However, an MDPCP Participant’s ability to obtain the minimum clinical quality/beneficiary experience score will be an absolute prerequisite for an MDPCP Participant’s ability to retain any portion of the PBIP, such that MDPCP Participants cannot retain the clinical quality/patient experience-based or the utilization-based portion of their PBIP unless they obtain a minimum clinical quality/ beneficiary experience score of 50%. Further details from CMS regarding the PBIP calculation will be included in the Practice Participation Agreement and FQHC Participation Agreement.

The MDPCP Participant’s performance on the quality/patient experience component of the PBIP will be based on performance on eQMs and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician & Group Survey metrics.⁸ The MDPCP Participant’s performance on the utilization component will be based on Medicare claims-based measures of inpatient admissions and ED visits, which are available in Healthcare Effectiveness Data and Information Set (HEDIS). Track 2 MDPCP Participants’ performance on the efficiency component will be based on the TPCC measure, using the specifications adapted from the Merit-based Incentive Payment System (MIPS) for Primary Care First.

Quality will be prioritized over utilization. CMS reserves the right to revise the measures used to

⁸ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

compute the PBIP in order to align with [State-wide Population Health Goals](#) under the TCOC Model. CMS will only add, revise, or drop measures after consultation with the MDH and other stakeholders. These measures will be revisited annually in conjunction with the State's proposals for Population Health Goals under the Model. MDPCP Participants will be made aware of any changes to the PBIP calculation methodology prior to the start of the Performance Year in which such changes are scheduled to take effect.

MDPCP Participants may concurrently participate in the MDPCP and be part of an ACO participating in the [Medicare Shared Savings Program](#) (Shared Savings Program). However, if an MDPCP Participant is a dual participant in the MDPCP and the Shared Savings Program, the MDPCP Participant will not be eligible to receive the PBIP, nor will its partner CTO Participant, if applicable, receive any PBIP associated with that MDPCP Participant. Instead, the total cost of care for the MDPCP Participant's attributed beneficiaries will be included in the expenditure calculations for the ACO under the Shared Savings Program. Such an MDPCP Participant will be required to report quality scores through the MDPCP, for monitoring and evaluation purposes, and must also take part in quality reporting through the ACO under the Shared Savings Program.

3. Comprehensive Primary Care Payments (CPCPs) for Track 2 Practices

In Track 2, to support the flexible delivery of even more comprehensive and coordinated care, CMS will pay MDPCP Participants in a hybrid fashion: part upfront PBPM (paid quarterly) and part reduced FFS (paid based on claims submission).

This upfront PBPM payment is called the Comprehensive Primary Care Payment (CPCP) and is paid based on an MDPCP Participant's historic Medicare payments for Evaluation & Management (E&M) services. No beneficiary cost-sharing is owed on the CPCP; beneficiary cost-sharing amounts will be based on the full FFS payment amount prior to the proportional reduction to account for the CPCP. Medicare FFS payments for E&M services during the Performance Year are then reduced proportionately to account for the upfront CPCP.

An MDPCP Participant's payment options will change based on how long the MDPCP Participant has been participating in Track 2 of the program, as shown in *Table 3*. To allow MDPCP Participants to gain experience with this hybrid payment model, Track 2 MDPCP Participants beginning MDPCP participation in Performance Year 2024 may select a 25% upfront CPCP payment (with 75% of the applicable FFS payment) for their first Performance Year of participation in Track 2 of the MDPCP. Track 2 MDPCP Participants also have the option to select a payment option with a greater portion of their E&M revenues in the form of a CPCP (either 40% or 65% in the form of a CPCP). However, for any year after the MDPCP Participant's first Performance Year in Track 2 of the program, the MDPCP Participant may not choose an option with a lower CPCP percentage than they selected for a previous Performance Year.

The CPCP and reduced FFS payment will apply only to office E&M services billed by the MDPCP Participants and paid by Medicare FFS. It is important to retain some unreduced FFS

payments to protect beneficiary access as well as to incentivize the provision of certain services (such as vaccine administration). In an effort to recognize practice diversity, CMS will allow MDPCP Participants to accelerate to an increased percentage of payment in the form of the CPCP over the course of their participation in Track 2 of the MDPCP, as illustrated in *Table 3*.

Table 3. Comprehensive Primary Care Payment Options Available to Track 2 MDPCP Participants Beginning Participation in PY2024

	Yr1 in MDPCP Track 2	Yr2+ in MDPCP Track 2
Percent of E&M Revenues through CPCP	25% / 75%	N/A
versus		
Percent of E&M Revenues through FFS	40% / 60%	40% / 60%
	65% / 35%	65% / 35%

When both the upfront CPCP and reduced FFS payments are taken together, the payment structure is designed to increase Medicare FFS revenue by between 4% – 6.5% over an MDPCP Participant’s historical level, not including CMF payments and PBIPs. An increase of 6.5% is expected for MDPCP Participants that choose the 65% upfront CPCP option, while a 4% increase in such revenue is expected for those that choose the 40% upfront CPCP option.

CMS will conduct a reconciliation based only on E&M services furnished by practitioners not on the MDPCP Participant’s Practitioner Roster to attributed Medicare beneficiaries. Under this partial reconciliation construct, CMS presumes that beneficiaries unsatisfied with the care they receive from practitioners on an MDPCP Participant’s roster are more likely to receive primary care services from other practitioners. Thus, increases in E&M services delivered by practitioners other than those on the MDPCP Participant’s Practitioner Roster to practice-attributed beneficiaries would lead to a partial recoupment of the CPCP from a MDPCP Participant. Conversely, significant decreases in E&M services delivered by practitioners other than those on the MDPCP Participant’s Practitioner Roster could lead to an additional CPCP payment to an MDPCP Participant. This type of partial reconciliation would protect CMS from spending significantly more on E&M services across all primary care practices in Maryland.

Track 3 Payments

1. Total Primary Care Payment: Flat Visit Fee (FVF) and Population-Based Payment (PBP)

Similar to the PCF Model, Track 3 will include a FVF paid by CMS to the Participant Practice for select primary care services (SPCS) defined below, and a PBP, paid prospectively on a

quarterly basis. Practices will continue to submit claims for the SPCS on a FFS basis. The FVF is then paid in lieu of the regular Medicare FFS rates for the SPCS. The FVF payment amount will be calculated using the weighted average payment rate for SPCS, where each SPCS rate is weighted by the historic billing frequency of that SPCS relative to the historic billing frequency of all other SPCS Healthcare Common Procedure Coding System (HCPCS) codes. CMS will determine the historic billing frequency for each SPCS code using historical Medicare FFS expenditure data from all non-FQHC Track 2 Participant Practices and, as applicable, Track 3 Participant Practices. The SPCS are identified by the following HCPCS codes, as modified from time to time: 99202-99205, 99211-99215, 99354, 99355, 99441-99443, 99421-99423, 99453, 99454, G2012, G2010, G2212.

CMS will calculate the FVF payment amount separately for facility and non-facility settings to reflect the different FFS payment rates for the SPCS in each of these settings and the different billing frequency of the SPCS in each of these settings.

In order to ensure that patient cost-sharing is not affected by the FVF, the FVF only changes the Medicare payment to the Participant Practice for SPCS furnished to attributed beneficiaries. It does not change the allowed amount on the claim used to calculate beneficiary cost-sharing amounts and deductibles. To calculate the portion of the SPCS amount attributable to Medicare payments (rather than beneficiary out-of-pocket costs), CMS multiplies the weighted average SPCS amount by 70% to remove the beneficiary cost-sharing obligation of 20% combined with 10% to reflect an estimate of the Medicare beneficiary’s deductible. CMS expects MDPCP Practices to collect the full amount of cost-sharing from attributed beneficiaries based on the actual Medicare allowed amount on the SPCS claim, not the FVF.

After the weighted SPCS is reduced by 30% to account for beneficiary out-of-pocket costs, 60% of this amount is paid to the Participant Practice FFS as the FVF. CMS will update the FVF amount on an annual basis to reflect recent billing patterns and updated payment rates for the SPCS HCPCS codes defined above.

For Performance Year 2024, CMS estimates the FVF as illustrated in *Table 4: Track 3 Participant Practice Projected FVF Payment Amounts*. CMS will update the FVF estimate below to reflect more recent billing frequency and 2024 PFS rates in the fall of 2023 and will inform potential participants of the exact FVF payment amount for Performance Year 2024 in the *MDPCP Payment Methodologies Paper*. *Table 5: Geographic Adjusted Flat Visit Fee Payment Rate by Practice Care Setting* displays the FVF payment rates including geographic adjustments by Maryland region.

Table 4: PY 2024? Track 3 Participant Practice Projected FVF Payment Amounts

Setting	FVF Payment Amount
Non-Facility	\$46.69
Facility	\$35.22

Table 5: PY 2024 Geographic Adjusted Flat Visit Fee Payment Rate by Practice Care Setting

Care Setting	Location		
	Rural MD	Baltimore / Surrounding Counties	Suburbs of DC in MD
Non-Facility	\$47.58	\$49.73	\$53.00
Facility	\$35.89	\$37.51	\$39.98

The 40% remainder of the weighted SPCS will then be used to determine the amount of the prospective PBP. The PBP is a per beneficiary per month (PBPM) amount that is paid quarterly to Participant Practices in Track 3. CMS will calculate the PBP amount by first calculating the Base PBP. The Base PBP is the sum of 40% of 70% of the weighted average of SPCS claims, plus the CMF, not including the HEART payment portion of the CMF, and PBIP amounts that would have been paid to the MDPCP Practices in that risk tier if the MDPCP Practice were participating in Track 2. As with the FVF, for 2024, CMS will calculate the weighted average of SPCS claims using claims data from all non-FQHC practices participating in Track 2 from September 2022 through August 2023 to allow CMS to calculate the payments ahead of the performance year. Similar to the FVF, for future MDPCP performance years (2025-2026), CMS intends to look at the MDPCP Track 3 practices' prior calendar year's billing frequency and updated Physician Fee Schedule rates to update the PBP payment amounts.

To determine the amount of the PBPM PBP for a Track 3 Participant Practice, CMS will first establish the Participant Practice's average CMS Hierarchical Condition Category (CMS-HCC) risk score for its population of attributed beneficiaries. CMS will then place the Track 3 Participant Practice into 1 of 5 risk tier groups. The risk tier groupings are determined using the average CMS-HCC risk scores across all Track 3 Participant Practices with the following percentile cut points: 40/60/80/90. *Table 6: Practice Risk Tier Groups and Corresponding PBPs* illustrates the amount of PBP (PBPM) based on a Participant Practice's risk tier group prior to geographic and other adjustment factors.

The PBP amount increases in higher risk tier groups to account for the increased resources required for Participant Practices to care for patients with more complex needs given their higher disease burden. This risk tier methodology was adapted by the Maryland TCOC Model team from the PCF payment methodology by increasing the risk tier groupings from four groupings under PCF to five groupings under MDPCP Track 3.

CMS will perform an annual reconciliation process to adjust the PBP to account for out-of-Participant Practice utilization as described below. CMS will also perform a quarterly reconciliation process to adjust the PBP amount to account for changes in attributed beneficiary Medicare eligibility and practice risk tier groupings. For future MDPCP performance years

(2025-2026), CMS intends to look at the Track 3 Participant Practices’ prior calendar year’s billing frequency and updated Physician Fee Schedule rates to update the SPCS weighted average portion of the PBP payment amounts.

Table 6: Practice Risk Tier Groups and Corresponding PBPs

Practice Risk Tier Group	Percentiles	PBP (PBPM)
Group 1	<40 th Percentile	\$35.89
Group 2	40 th to <60 th Percentile	\$40.26
Group 3	60 th to <80 th Percentile	\$43.41
Group 4	80 th to <90 th Percentile	\$47.79
Group 5	>= 90 th Percentile	\$57.83

Track 3 Participant Practices will also be held accountable for attributed beneficiaries’ costs and quality of care, using performance measures that are the same as the measures used in calculating the PBIP for Participant Practices in Track 2 (i.e., TPCC, Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®) Patient Experience of Care Survey, eCQMs, Acute Hospital Utilization (AHU), and Emergency Department Utilization (EDU)). Specifically, Track 3 Participant Practices will be assessed on their performance on the quality, utilization, and efficiency measures specified in *Table 7: MDPCP Quality, Utilization and Efficiency Measures*. The MDPCP quality, utilization, and efficiency measures are directly aligned with the State’s population health goals and the Statewide Integrated Health Improvement Strategy.

However, Track 3 will differ in how risk is structured as compared to Track 2. Track 3 imposes financial risk on Track 3 Participant Practices through the PBA. The PBA is an adjustment applied to the Total Primary Care Payment (TPCP), defined as the PBP and the FVF. The PBA ranges from negative 10% to positive 25% of the TPCP, depending on a given Participant Practice’s performance on the measures specified in *Table 7: MDPCP Quality, Utilization and Efficiency Measures*. As illustrated in *Table 8: MDPCP Track 3 PBA Risk Framework*, scoring breakpoints will be set so that the PBA is budget neutral across Track 3 Participant Practices (i.e., negative 10% adjustments will fund the positive 25% adjustments across Track 3 Participant Practices). Track 3 Participant Practices will be assessed on their performance on the quality measures specified in *Table 7: MDPCP Quality, Utilization and Efficiency Measures*. In terms of timing, for Track 3 Participant Practices that begin participating in MDPCP Track 3 in performance year 2024, CMS will assess their performance year 2024 performance on the quality measures specified in *Table 7* in performance year 2025, and CMS will apply the PBA to their TPCP beginning in the third quarter of 2025. CMS will then apply the PBA to the Participant Practice’s TPCP for the next four quarters.

Table 7: MDPCP Quality, Utilization and Efficiency Measures

Measure	Type	Measure Steward (ID, if applicable)	Benchmark
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Outcome	NCQA (CMS122)	MIPS (National)
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	CMS (CMS69)	MIPS (National)
Controlling High Blood Pressure	Outcome	NCQA (CMS165)	MIPS (National)
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/ Outcome	CMS (CMS2)	MIPS (National)
EDU and AHU	Outcome	NCQA HEDIS	State Medicare FFS
Patient experience of care	-	CAHPS	National CG CAHPS - PCMH
Total Per Capita Cost (Risk Adjusted Total Cost of Care measure)	Outcome	TBD	State Medicare FFS

Table 8: MDPCP Track 3 PBA Risk Framework

Practice percentile versus benchmark range*	Percentage payment adjustment to the TPCP
0-10	-10%
10-40	-5%
40-75	0% (no adjustment)
75-90	+5%
90-95	+10%
95-100	+25%

* PBA calculations are based on MDPCP Participant Practice-level performance scores that are compared to similar scores calculated for a benchmark reference population made up of non-MDPCP practices.

2. HEART Payment

CMS will make a HEART payment to Participant Practices in Track 3. While the Track 3 HEART payment is a separate payment and not a component of the CMF, as in Track 2, the Track 3 HEART payment will be paid on a per beneficiary per month basis for all attributed beneficiaries in the highest ADI quintile and who fall into the 4th or Complex CMS-HCC risk

tiers. The HEART payment is not subject to recoupment or adjustment based on practices' performance on quality, utilization, and efficiency measures.

C. Partnerships between MDPCP Participants and CTOs

Under the MDPCP, MDPCP Participants will be allowed to partner with a CTO Participant. Applicant Practices and Applicant FQHCs may identify a first and second choice of the CTOs with which they would like to partner during the application process for primary care practices and FQHCs. CTOs will indicate their geographic coverage area, comprised of a county or counties in Maryland, in their applications. Following the application period, CMS will announce a list of CTOs selected to participate in the MDPCP. Applicant Practices and Applicant FQHCs will then have the opportunity to update the list of CTOs with which they would like to partner to include one or more of the CTOs that CMS has selected to participate in the MDPCP. While MDPCP Participants are not required to partner with a CTO, CTO Participants must partner with any MDPCP Participant that wishes to partner with them unless the CTO is unable to do so due to staffing limitations or because the MDPCP Participant is outside of the CTO's geographic coverage area. If an MDPCP Participant wishes to partner with a CTO that has reached capacity and/or if the MDPCP Participant is outside of the CTO's geographic coverage area, CMS will make a determination as to which CTO may partner with the MDPCP Participant. Each year, at a time and in a manner specified by CMS, MDPCP Participants may request to switch CTOs or choose not to partner with any CTO.

CMS expects that Medicare beneficiaries attributed to an MDPCP Participant will receive the same types of care management services regardless of the CTO partnership status of the MDPCP Participant to which they have been attributed. Similarly, all MDPCP Participants will be required to meet the same five Comprehensive Primary Care Functions of Advanced Primary Care regardless of whether the MDPCP Participant has partnered with a CTO. In each instance, the MDPCP Participant remains responsible for meeting the applicable care transformation requirements. Failure to meet these care transformation requirements may result in remedial action or termination of an MDPCP Participant's participation agreement with CMS, regardless of whether the MDPCP Participant has partnered with a CTO.

If a Track 2 MDPCP Participant partners with a CTO, CMS will make a CMF payment to the partner CTO. CMS will pay the CTO the CMF payment directly and will reduce monthly CMF payments to the CTO's partner MDPCP Participant(s) by a corresponding amount. The overall CMF amount paid by CMS to both the MDPCP Participant and the CTO will be based on the number of Medicare beneficiaries attributed to the CTO's partner MDPCP Participant(s).

If a Track 3 Participant Practice partners with a CTO, CMS will make a PBP payment directly to the partner CTO and will reduce the quarterly PBP payments to the CTO's partner Participant Practice(s) by a corresponding amount. CMS will also make a HEART payment directly to the partner CTO and will reduce the CTO's partner Participant Practice's HEART payment amount by a corresponding amount, as further described in the CTO Payment Option sections below.

Each MDPCP Participant that chooses to partner with a CTO may choose one of two CTO payment options described in this section of the RFA. Under both CTO payment options, CTOs must hire care management professionals and deploy them at the direction of the partner MDPCP Participant and in accordance with the Practice Participation Agreement or FQHC Participation Agreement, as applicable, and the CTO Participation Agreement. Care management professionals may spend part of their time furnishing services to Medicare beneficiaries attributed to each of the CTO’s partner MDPCP Participants, as the primary purpose of the CTO’s participation in the MDPCP is to support MDPCP Participants who may not be able to provide additional resources full-time. The CTO must deploy an interdisciplinary care management team and is expected to develop strong linkages with behavioral health providers. In supporting the CTO’s partner MDPCP Participants in meeting the care transformation requirements, the CTO must focus on building an interdisciplinary care management team to furnish care coordination services to Medicare beneficiaries attributed to MDPCP Participants.

Under both CTO payment options, an MDPCP Participant must also use semiannual practice reporting (in the MDPCP Portal) to demonstrate its progress toward meeting the applicable care transformation requirements with the support of a CTO. The CTO must support partner MDPCP Participants in fulfilling the applicable care transformation requirements by performing the activities applicable to the CTO payment option selected by the partner Participant Practice and attest to this support in the partner MDPCP Participant’s semiannual reporting.

1. CTO Payment Option 1

For each partner MDPCP Participant in Track 2, the CTO Participant will receive 50% of the CMF payment (including the HEART payment); the remaining 50% of the CMF will be paid to the partner MDPCP Participant. For each partner Participant Practice in Track 3, due to different payment structures specified in the *Track 3 Payments* section above, the CTO will receive 40% of the PBP payment and the HEART payment; the remaining 60% of the PBP and the HEART payment will be paid to the partner Participant Practice. CTO payment Option 1 is illustrated in *Table 9: CTO Payment Option 1 by Track*.

Table 9: CTO Payment Option 1 by Track

MDPCP Participant Track	CTO CMF Share	Practice CMF Share
2	50%	50%
3	40%	60%

Under Option 1, the CTO will provide each partner MDPCP Participant with at least one Lead Care Manager. The Lead Care Manager is defined as an individual who is fully dedicated to care management functions of the MDPCP Participant under the MDPCP. The Lead Care Manager must work with the practitioners of the MDPCP Participant who have primary responsibility for care management of all beneficiaries attributed to the MDPCP Participant. The CTO may

provide additional care management professionals as necessary to fulfill specialized care management needs that the MDPCP Participant may have. The CTO must support its partner MDPCP Participants in maintaining resources to provide care management to at least 5% of their attributed Medicare beneficiaries in care management. The CTO will be required to outline its service offerings in their application and will finalize the services offered to each partner MDPCP Participant in its CTO arrangement with the Participant Practice.

2. CTO Payment Option 2

For each partner MDPCP Participant in Track 2, the CTO Participant will receive 30% of the CMF (including the HEART payment); the remaining 70% of the CMF payment will be paid to the partner MDPCP Participant. For each partner Participant Practice in Track 3, due to different payment structures, the CTO will receive 24% of the PBP and HEART payment; the remaining 76% of the PBP and HEART payment will be paid to the partner Participant Practice. CTO payment Option 2 is illustrated in *Table 10: CTO Payment Option 2 by Track*.

Table 10: CTO Payment Option 2 by Track MDPCP Participant Track	CTO CMF Share	Practice CMF Share
2	30%	70%
3	24%	76%

Under Option 2, the partner MDPCP Participant has its own Lead Care Manager, so the CTO does not need to deploy a Lead Care Manager to the MDPCP Participant. However, the CTO will provide the MDPCP Participant with access to an interdisciplinary care management team. The CTO's interdisciplinary care management team will supplement the Lead Care Manager who is employed by the MDPCP Participant. The CTO must support its partner MDPCP Participant in maintaining resources to provide care management to at least 5% of their attributed Medicare beneficiaries in care management.

D. Use of Funds by CTOs

At the heart of the MDPCP is an interdisciplinary care management team centered on the needs of the beneficiary. During the CTO Participant's first Performance Year, CTOs will be required to spend at least 50% of their CMF payments on deploying care management professionals. The remaining 50% of the CTO's CMF payments must be used only to support the CTO's partner MDPCP Participants in meeting the applicable care transformation requirements and in accordance with the CTO Participation Agreement. Beginning in the CTO's second Performance Year, CTOs will be required to spend more than the majority of their CMF (with the exception of the HEART payment or HEART payment portion of the CMF payments) on deploying care management professionals. This adjustment will help ensure that comprehensive primary care is being furnished to beneficiaries attributed to partner MDPCP Participants. The main difference

between a CTO's first Performance Year and subsequent Performance Years is the percentage of the CMF and HEART payment that must be used to deploy care management professionals, as opposed to other activities, in support of the partner MDPCP Participants. The specific percentage of the CTO's CMFs and HEART payments that must be spent on deploying care management professionals will be determined by CMS in advance of each Performance Year and specified in the CTO Participation Agreement. CTOs may be required to report to CMS their CMF and HEART payment expenditures and spending ratios to assist CMS to determine appropriate CMF spending limitations, ratios, and requirements for CTOs in future Performance Years.

For purposes of a CTO's spending limitations, a care management professional is anyone who meets the definition of "auxiliary personnel" as defined at 42 CFR § 410.26(a)(1). Care management professionals do not include administrative staff, data analysts, or consultants. This requirement that a CTO spend a certain portion of the CMF payments received from CMS on deploying care management professionals does not prohibit a CTO from spending additional funds from another source on infrastructure, IT systems, or overhead necessary for the CTO to assist its partner MDPCP Participants in meeting the applicable care transformation requirements. The limitations on the use of CMF, PBP, and HEART payments will be further specified in the CTO Participation Agreement.

E. Accountable Payments for CTOs

CMS intends to hold CTOs with one or more partner MDPCP Participants in Track 2 accountable for their performance through a CTO-specific Performance-Based Incentive Payment (CTO PBIP) that is separate from the MDPCP Participants' PBIP. (MDPCP Participants that choose to partner with a CTO will receive their full at-risk PBIP from CMS, as long as those MDPCP Participants are not concurrently participating in a Shared Savings Program ACO). CMS will pay each such CTO an at-risk PBIP in the amount of \$4 PBPM based on the number of Medicare beneficiaries attributed to the CTO's partner MDPCP Participants in Track 2. CMS will pay the CTO PBIP prospectively, but will require the CTO to repay any part or all of their PBIP to CMS based on their partner practices' performance on the quality and utilization performance measures. The CTO will thus be at risk for the CTO PBIP amounts prepaid.

CMS intends to hold CTO Participants with one or more Track 3 partner Participant Practices accountable for their performance through the PBA. The CTO's performance for purposes of the CTO PBIP or PBA will be calculated using the same performance measures and calculation methodology applied to their partner MDPCP Participants. However, the CTO's performance will be calculated indirectly based on aggregated clinical quality/patient experience outcomes, utilization measures for all of the CTO's partner MDPCP Participants, as well as efficiency measure performance for all of the CTO's partner MDPCP Participants in Track 2 and Track 3. The applicable set of measures will be identified in the CTO Participation Agreement. Using

performance measures from the CTO's partner MDPCP Participants to determine whether CMS will recoup all or a portion of a CTO's PBIP creates an incentive for the CTO to help its partner MDPCP Participants to succeed under the MDPCP. Similarly, using performance measures from the CTO's Track 3 partner Participant Practices to determine the PBA that will be applied to the CTO's PBP creates an incentive for the CTO to help its partner Participant Practices to succeed under the MDPCP. CMS will apply the PBA to the PBP payment paid to the CTO. The amount of the PBA will depend on the CTO's partner Participant Practice's performance on the performance measures described in the MDPCP Participation Agreements. As discussed in [Section III, Part B](#) of this RFA, CMS reserves the right, after consultation with the State and relevant stakeholders, to revise the quality measures used to compute the CTO PBIP or PBA in order to align with the Population Health Goals under the Model.

CMS also reserves the right to add additional population health measures to the PBIP or PBA calculation methodology for CTOs that align with the State's Population Health Goals but differ from the measures used to calculate the PBIP for MDPCP Participants. For instance, CMS may hold MDPCP Participants accountable for process and outcome measures and hold CTOs accountable for outcomes measures at a broader geographic level. Any changes in the population health measures or methodology for the CTO PBIP or PBA will be made available to CTOs prior to the Performance Year in which such changes would take effect.

IV. Additional Supports and Information for Participant Practices

MDPCP Participants will have access to the MDPCP Portal, a website through which CMS will make assessment and feedback reports available to MDPCP Participants so they can understand their progress in building the capabilities required to deliver comprehensive primary care. CMS will also provide important program information through the MDPCP Portal, including a list of the MDPCP Participant's attributed beneficiaries and the MDPCP payment amounts that the MDPCP Participant will receive. Practices and FQHCs that participate in the MDPCP can expect a robust set of supports, including:

- Electronic MDPCP Portal:
 - Assessment and feedback reports
 - List of attributed Medicare beneficiaries
 - Prospective payment amounts based on number of attributed Medicare beneficiaries and Track of participation
- Medicare claims data on attributed Medicare beneficiaries (if requested by the MDPCP Participant)
- Learning Network:
 - MDH MDPCP Participant coaching
 - Connections to learning forums and to other MDPCP Participants in the State
 - Networking with other MDPCP Participants and CTO Participants

- A variety of guidance materials from CMS, including Getting Started with the MDPCP, Advancing Primary Care in the MDPCP, and the Performance Measures Guide.

A. The MDPCP Learning Network

The MDPCP will include a robust Learning Network to support MDPCP Participants in meeting their care transformation requirements. All MDPCP Participants and CTO Participants may participate in the MDPCP Learning Network. The MDPCP Learning Network will bring MDPCP Participants and CTO Participants together to facilitate peer-to-peer learning and to provide opportunities for sharing lessons learned and best practices.

The Learning Network will be comprised of both MDPCP Participant Networks and CTO Participant Networks. While some learning activities and resources will be designed for the entire Learning Network, other learning activities will be designed specifically for MDPCP Participants or CTO Participants.

The Learning Network has a specific set of goals:

1. **Provide guidance materials to MDPCP Participants and CTOs** on the five Comprehensive Primary Care Functions of Advanced Primary Care, eligibility requirements, and requirements for participation in the MDPCP.
2. **Understand and share** the changes that MDPCP Participants make and the specific tactics they deploy to achieve their aims in the MDPCP in order to facilitate peer-to-peer learning and innovation and to create communities of MDPCP Participants and CTO Participants.
3. **Foster peer-to-peer learning and innovation for MDPCP Participants and CTOs** via an online collaboration platform to support sharing within and across Tracks.
4. **Leverage the health IT, data capabilities, and community and stakeholder resources** in Maryland to support MDPCP Participants in delivering comprehensive primary care.
5. **Coach and facilitate MDPCP Participants** in meeting MDPCP care transformation requirements and building the workflows required for participants to improve care, improve health outcomes, and reduce total cost of care.

To achieve these goals, the MDH will sponsor a series of learning activities to bring together groups of MDPCP Participants and CTO Participants to learn from each other. The work of the Learning Network will be informed by MDPCP Participants and CTO Participants to move both groups toward success in the MDPCP.

To achieve their aims in the MDPCP, most MDPCP Participants will need to redesign the care they furnish. The MDPCP Learning Network is designed to support and facilitate MDPCP Participants as they make these changes, led from within.

B. Data Sharing

In the MDPCP, CMS will provide MDPCP Participants and CTO Participants with regular data feedback to help inform their care transformation efforts. Specifically, CMS will provide MDPCP Participants and CTO Participants with the opportunity to request practice-level and certain beneficiary-level Medicare beneficiary data (Parts A and B claims) for use in care management and quality improvement purposes. MDPCP Participants and CTO Participants that request such data may reuse the data only in accordance with applicable laws, their respective MDPCP participation agreements, and other controlling documents such as data use agreements.

The State will provide MDPCP Participants and CTO Participants that request such data with monthly practice-level feedback reports. Such reports could summarize Medicare FFS cost and utilization, as well as provide beneficiary-level lists of ED visits, hospitalizations, and other high-cost services (e.g., imaging) used during the previous calendar quarter. The State may also offer reports of cost and quality data about subspecialists to help MDPCP Participants work with cost-effective specialty partners.

MDPCP Participants will also report quality metrics to CMS for purposes of the PBIP, PBA, and monitoring and compliance purposes. MDPCP Participants will be required to submit eQMs to the State under the terms of the Practice Participation Agreement or FQHC Participation Agreement, as applicable; the State will, in turn, provide that information to CMS.

All data sharing and data analytics in the MDPCP will comply with applicable law, including the regulations promulgated under HIPAA, as amended. Medicare beneficiaries may opt out of CMS providing this form of data sharing with MDPCP Participants and CTO Participants by contacting the MDPCP helpdesk via phone directly or through an MDPCP Participant, as specified in the MDPCP Practice Participation Agreement.

C. Concurrent Participation in Other CMS Initiatives

MDPCP Participants may participate in both the MDPCP and other CMS initiatives (including, without limitation, the [Accountable Health Communities Model](#) and the [Medicare Diabetes Prevention Program Expanded Model](#)), with the exception of those initiatives that would require participating health care providers to appear on a Participation List or an Affiliated Practitioner List as those terms are defined for purposes of the [Quality Payment Program](#). Of note, MDPCP Participants are not permitted to participate in the Innovation Center's ACO REACH Model.

There are two exceptions to this rule:

1. **Medicare Shared Savings Program.** Primary care practices and FQHCs may participate concurrently in the MDPCP and in any track of the Shared Savings Program. Primary care practices concurrently participating in Track 2 of the MDPCP and a Shared Savings Program ACO will forego the prospectively paid, retrospectively reconciled PBIP in the MDPCP, and instead will participate in the MSSP's shared savings/shared losses arrangement. MDPCP Track 3 practices participating in the Medicare Shared Savings

Program will not be eligible to receive the PBA. For additional information on the PBA, please refer to [Section III, Part B, Track 3 Payments](#) above.

2. **Care Redesign Program.** Healthcare providers participating in the Maryland TCOC Model’s [Care Redesign Program](#) (CRP) as a Care Partner for one or more CRP participant hospitals may be eligible to participate concurrently in the MDPCP. Each CRP Track has a specific set of Care Partner Qualifications that limit what types of providers and suppliers may participate as Care Partners for that Track, and such qualifications may prohibit practitioners from participating concurrently in the MDPCP. Any such prohibitions will be identified in the CRP Track’s Care Partner Qualifications set forth in the Track Implementation Protocol. CMS retains the right to establish and amend the Care Partner Qualifications for each CRP Track and prohibit certain types of providers and suppliers from participating in the MDPCP.

D. The Quality Payment Program

Advanced APM Status

Under the Quality Payment Program, certain components of the Model (namely the hospital payment program and the MDPCP) qualify as Advanced Alternative Payment Models (Advanced APMs). MDPCP Track 3 meets the criteria to be an Advanced APM. The financial risk standards applied in making this determination with respect to the MDPCP are the financial risk and nominal amount standards specific to medical home models. The Medical Home Model financial risk and nominal amount standards apply only to an APM Entity (here, the Participant Practice) that is owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization’s subsidiary entities (referred to as the “50 eligible clinician limit”).

The APM entity under the MDPCP is the Participant Practice. Eligible clinicians who are on the Participation List (Practitioner Roster) of an MDPCP Track 3 Participant Practice that does not exceed the 50 eligible clinician limit would be considered participants in an Advanced APM through the MDPCP. However, eligible clinicians included on the Practitioner Roster for a Participant Practice that exceeds the 50 eligible clinician limit would not become Qualifying APM Participants (QPs) through participation with a Participant Practice in MDPCP Track 3. Eligible clinicians in these Participant Practices are subject to the MIPS reporting requirements and payment adjustment unless they are otherwise excluded, while eligible clinicians who are QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

With respect to the Quality Payment Program incentives that will apply for QPs and others in CY 2024 and beyond, we direct readers to the CY 2023 Physician Fee Schedule Final Rule (87 FR 70114).

MIPS APM Status The MDPCP is a MIPS APM and thus requires MIPS reporting for Track 2

practices that are not otherwise considered an APM entity. Only MIPS eligible clinicians (MIPS ECs) are subject to the MIPS payment adjustments. MDPCP Participants that are FQHCs may be exempt from MIPS if they bill for Medicare Part B services exclusively through the FQHC payment methods because MIPS does not apply to these facility payments. However, if the FQHC Participant bills for Medicare Part B services under the PFS, then payment for such other services would be subject to the MIPS payment adjustments unless the FQHC Participant's billing thresholds are below the low volume exclusion threshold determination or the FQHC Participant meets another exclusion. For more information regarding MIPS please refer to the Quality Payment Program website: <https://qpp.cms.gov/>.

Concurrent Participation in the Shared Savings Program The ENHANCED Track and the BASIC Track (Level E, only) of the Shared Savings Program are Advanced APMs. Primary care practices concurrently participating in Track 2 of the MDPCP and a Shared Savings Program ACO will forego the prospectively paid, retrospectively reconciled PBIP in MDPCP, and instead will participate in the ACO's shared savings/shared losses arrangement. Primary care practices concurrently participating in Track 3 of the MDPCP and a Shared Savings Program ACO will not be eligible to receive the PBA.

More information about the Quality Payment Program is available at <https://qpp.cms.gov/>.

E. Telehealth Benefit Enhancement

An MDPCP Participant in any MDPCP Track may furnish certain primary care services that are also Medicare telehealth services via telehealth, regardless of the geographic area or site of service of the MDPCP beneficiary, including in the MDPCP beneficiary's home. Specifically, this benefit enhancement applies to the following Medicare telehealth services: Telephone E&M: 99441-99443; Virtual Check in: G2012; FQHC Virtual Communication Services: G0071; and, FQHC Distant Site Telehealth visit: G2025(though these codes may change from time to time). The ability to furnish these services under the terms of the benefit enhancement are subject to certain conditions and safeguards specified in the MDPCP Participation Agreements. For example, the services must be medically necessary and must be furnished by the MDPCP Participant to MDPCP beneficiaries under the Model.

V. Requirements and Reporting

MDPCP Participants and CTO Participants will be required under their respective participation agreements with CMS to report certain operational data as well as other information to CMS through the MDPCP Portal. Reporting by MDPCP Participants and CTO Participants allows CMS to track progress on the relevant program requirements and to understand the MDPCP Participant's and CTO Participant's capabilities. Each MDPCP Participant will also be required to report on the quality of care it provides.

A. Care Transformation Requirements

MDPCP Participants must meet the applicable care transformation requirements related to the five Comprehensive Primary Care Functions of Advanced Primary Care, including designating a Lead Care Manager. These requirements may change over the course of the MDPCP. CMS will notify participants of any such changes to the care transformation requirements at least one calendar quarter prior to the start of the Performance Year in which such changes would take effect. CMS will provide guidance regarding how to meet and report practice care transformation requirements. This guidance will be made available to Participant Practices and participating CTOs annually.

Both MDPCP Participants and CTO Participants will be required to complete reporting semiannually through the MDPCP Portal in order to demonstrate that MDPCP Participants are making progress toward or have successfully met the applicable care transformation requirements. CMS will also collect other programmatic information, including information regarding the use of any CMFs and HEART payments paid to MDPCP Participants and CTO Participants. Failure to complete the reporting requirements under the terms of the Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement, as applicable, may result in remedial action or in termination from the MDPCP.

As discussed previously, an MDPCP Participant in Track 2 may spend the CMF received from CMS on any of the five Comprehensive Primary Care Functions of Advanced Primary Care, but the MDPCP Participant will be required to provide an annual report on how the funds were spent. For a CTO Participant, all CMF payments received from CMS must be spent on deploying care management professionals and to assist partner MDPCP Participants in meeting their care transformation requirements. Use of the PBIP by both MDPCP Participants in Track 2 and CTO Participants, and of CPCP payments by Track 2 MDPCP Participants, will not be restricted under the terms of the Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement.

B. Quality Reporting

The MDPCP includes a robust quality strategy to ensure that the program meets its goal of improving care for Maryland's Medicare beneficiaries. CMS will use eQMs, patient experience of care surveys, and utilization measures to track beneficiary experience and the quality and cost of care; to identify gaps in care; and to focus quality improvement activities. High quality of care, quality improvement, or both, will also be incentivized through the PBIP retention policy if an MDPCP Participant is participating in Track 2, or the potential to receive a positive PBA if an MDPCP Participant is participating in Track 3, as outlined in [Section III](#) of this RFA.

MDPCP Participants in all Tracks will be required to report annually on practice-level eQMs. A tentative list of eQMs for Performance Year 2024 appears in [Appendix 1](#) of this RFA. The final list of eQMs for Performance Year 2024 will be listed in the Practice Participation

Agreement and FQHC Participation Agreement. CMS may update the eCQM list for future Performance Years. Instructions regarding the submission of eCQMs appear in the *MDPCP Performance Measures Guide*. CMS will assess each MDPCP Participant's performance on the eCQMs, utilization measures, and patient experience of care measures when calculating the PBIP for MDPCP Participants in Track 2, and the PBA for MDPCP Participants in Track 3.

In addition, MDPCP Participants are required to do the following:

- Use a 2015 or later edition certified EHR technology. This requirement may be updated to be consistent with future Quality Payment Program requirements;
- Achieve full connectivity with an HIE by the start of the MDPCP Participant's first year of participation in the MDPCP; and
- Electronically report eCQMs to CMS via the State's designated HIE or a similar product from another HIE.

CMS may update the quality measures that MDPCP Participants must report for future Performance Years. CMS may solicit feedback from stakeholders on which measures MDPCP Participants should be required to report under the MDPCP. CMS also intends to incorporate measures based on the State's population health goals that broadly represent the focus of the Model (which includes an aim for large, long-term impacts on population health), into the PBIP and PBA calculation methodologies.

1. Electronic Clinical Quality Measures

The use of eCQMs ensures practitioners affiliated with MDPCP Participants and MDPCP Participants have insight into the quality of the care they provide. The eCQMs were selected from the portfolio of health IT-enabled measures included in other CMS quality reporting programs. Measures from each of the six quality domains (i.e., patient safety, effective clinical care, person and caregiver-centered experience and outcomes, communication and care coordination, community/population health, and efficiency and cost reduction) are included in the set.

The MDPCP eCQM measures that MDPCP Participants will be required to report target a primary care beneficiary population, and, where feasible, are outcome measures instead of process measures. A tentative list of such measures is provided in [Appendix 1](#).

2. Patient Experience of Care

A subset of the CAHPS® Clinician & Group Survey will be administered by CMS to a sample of the MDPCP Participant's entire patient population to measure experience of care.

3. Patient-Reported Outcome Measures

In addition, for Medicare beneficiaries attributed to Track 2 and Track 3 MDPCP Participants, CMS may collect Patient-Reported Outcome Measures (PROMs) survey data, after the surveys

are administered by MDPCP Participants, to screen for and capture attributed beneficiaries' reported clinical outcomes for a set of common medical and social problems that are disease agnostic—such as depression, problems with physical functioning, social isolation, or pain—instead of focusing only on beneficiaries with a specific disease or condition. To identify attributed beneficiaries with complex medical needs, MDPCP Participants may be required to administer the PROMs surveys at CMS-specified intervals during each Performance Year.

C. Program Integrity, Monitoring, and Remedial Action

CMS will conduct a program integrity screening on Applicant Practices, Applicant FQHCs, Applicant CTOs, and MDPCP Participants. CMS will also conduct a program integrity screening on all NPIs listed on each Participant Practice's Practitioner Roster in combination with the primary care practice's associated TIN. FQHC Participants will be required to undergo the program integrity screening, but CMS will not conduct a program integrity screening on their NPIs, as FQHC Participants are not required to submit to CMS a list of NPIs on a Practitioner Roster. The results of a program integrity screening may be used by CMS to reject an application, to terminate a participation agreement, or to take other remedial action against a Participant Practice, Participant FQHC, or CTO Participant. Additionally, MDPCP Participants and CTO Participants will be subject to documentation and reporting requirements and will be required to participate in CMS' monitoring of the MDPCP in order to help CMS ensure appropriate and effective implementation of the program. Monitoring is essential to ensure that beneficiaries' experiences and quality of care is either maintained or improved, and that MDPCP Participants and CTO Participants comply with the Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement, respectively. Moreover, monitoring helps CMS confirm that MDPCP Participants and CTO Participants understand and can track their progress towards meeting the applicable care transformation requirements.

The Practice Participation Agreement, the FQHC Participation Agreement, and the CTO Participation Agreement will set forth specific monitoring activities, which may include, without limitation, CMS review of the following:

- *Care Transformation Requirements Achievement Data:* Substantiation of semiannual MDPCP Participant and CTO Participant reporting on care transformation activities and progress submitted to CMS.
- *Compliance with the Participation Agreement:* Confirmation that MDPCP Participants submitted required notifications to CMS, did not engage in beneficiary inducement activities, etc. CMS will perform audits and inspections on MDPCP Participants' submissions and may request additional MDPCP Participant records as a result of an audit.
- *Practice Revenue and Expense Data:* Annual MDPCP Participant and CTO Participant submissions to CMS, including a retrospective look at the MDPCP Participant's and CTO Participant's actual use of CMFs and HEART Payment or, for those MDPCP Participants that are primary care practices participating in Track 3, the

actual use of the PBP.

- *Cost, Utilization, Patient Experience, and Quality Data:* Review of cost, utilization, patient experience, and quality data on a least an annual basis to identify MDPCP Participants and CTO Participants that are or are not performing well.

Track 2 and Track 3 MDPCP Participants may be subject to monitoring and/or feedback from CMS to assess whether they are stinting on care and whether such activity may be related to the partially capitated payment rate under the CPCP (if the MDPCP Participant is participating in Track 2) or the PBP (if the MDPCP Participant is participating in Track 3).

In addition to the monitoring activities described above, MDPCP Participants and CTO Participants will be required to maintain copies of all documentation related to their actual expenditures of MDPCP payments and their care delivery and transformation work under the MDPCP for a period of at least 10 years. MDPCP Participants and CTO Participants will also be subject to audit by CMS. To the extent possible (and practicable), MDPCP Participants and CTO Participants will receive advance notice of upcoming audits. CMS may decide to audit an MDPCP Participant and/or a CTO Participant based on the MDPCP Participant's performance on utilization and quality measures, entity revenue and expense data, and other practice-reported information.

During the MDPCP performance period, CMS may determine that certain MDPCP Participants and CTO Participants should be subject to remedial action, such as a Corrective Action Plan (CAP), suspension of MDPCP payments, or even termination from the MDPCP. Remedial action may be imposed when CMS determines that an MDPCP Participant or CTO Participant does not meet the terms of its participation agreement, fails to meet the MDPCP's quality standards, or under certain other circumstances to be specified in the Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement. MDPCP Participants and CTO Participants subject to a CAP will be expected to implement the corrective actions described in the CAP within a specified time frame. MDPCP Participants and CTO Participants that fail to successfully implement a CAP or otherwise cannot address areas of concern or that are unable to meet the requirements of their Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement, as applicable, may be terminated from the MDPCP by CMS.

D. Participation in CMS' Evaluation

All participants in the MDPCP, including both MDPCP Participants and CTO Participants, will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the Model, which may include: participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will be used to inform CMS about the effect of the MDPCP within the Maryland TCOC Model and its ability to affect primary care transformation and aligned

payment reform in Maryland.⁹

VI. Authority to Test Model

Section 1115A of the Act established the Innovation Center, and provides authority for the Innovation Center to test innovative payment and service delivery models that are expected to reduce Medicare, Medicaid, and CHIP spending while preserving or enhancing the quality of beneficiaries' care.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide not to move forward with all or part of the Model, including the MDPCP, for any reason and at any time, as is true for all models tested under section 1115A authority. Similarly, as implementation of the MDPCP progresses, CMS reserves the right to terminate or modify the Model, including the MDPCP, if it is deemed that it is not achieving the goals and aims of the initiative or section 1115A of the Act.

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). No fraud and abuse waivers are being issued for the MDPCP under the Maryland TCOC Model. Thus, notwithstanding any other provision of this RFA or the MDPCP Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement, all individuals and entities must comply with all applicable fraud and abuse laws and regulations.

VII. Amendment

CMS may revise the terms of the MDPCP in response to operational or other matters. The terms of the MDPCP as set forth in this RFA may differ from the terms of the MDPCP as set forth in the Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement. Unless otherwise specified in the relevant participation agreement, the terms of the participation agreements, as amended from time to time, shall constitute the terms of the MDPCP.

⁹ See generally 42 C.F.R. § 403.1110.

Appendix 1: MDPCP Tentative Quality, Utilization, and Efficiency Set for Performance Year 2024

QUALITY COMPONENT

MDPCP eCQM Set			
CMS ID#	Measure Title	Measure Type/ Data Source	Domain
CMS165v11	Controlling High Blood Pressure	Outcome/eCQM	Effective Clinical Care
CMS122v11	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Outcome/eCQM	Effective Clinical Care
CMS69v11	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process/eCQM	Population Health
CMS2v12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process/eCQM	Population Health

CG-CAHPS Measure		
Domain	Source	Measure Title
Patient Experience	NQF#0005	CG-CAHPS survey

UTILIZATION COMPONENT

Utilization Measures			
Utilization	Emergency Department Utilization	HEDIS	Ambulatory care: summary of utilization of ambulatory care in the following categories: ED visits
Utilization	Acute Hospital Utilization	HEDIS	The Acute Hospital Utilization (AHU) measure (previously titled Inpatient Hospital Utilization [IHU]) assesses the rate of acute hospitalizations and observation stay discharges among members 18 years of age and older. Medicare and commercial health plans report the measure in three categories: surgery, medicine and total hospitalizations. The measure is risk-adjusted for age, gender and comorbid conditions.

EFFICIENCY COMPONENT

Efficiency Measure			
Domain	Measure Title	Source	Measure Description
Efficiency	Total per Capita Cost (TPCC)	MIPS	CMS takes the per-capita standardized allowed amount of Medicare Parts A+B spending, with exclusions for anesthesia, radiation, and chemotherapy services, for MDPCP Beneficiaries attributed to the MDPCP Practice Site during a given beneficiary month (observed) and divides by an expected allowed amount. The expected allowed amount is the predicted value of a simple linear regression of Maryland Medicare beneficiaries' Hierarchical Condition Category (HCC) risk scores. The MDPCP Practice's performance on the TPCC measure is compared to the TPCC performance benchmark for Maryland established by CMS.

Appendix 2: Tentative Care Transformation Requirements

The Care Transformation Requirement tables below are tentative Care Transformation Requirements for Performance Year 2024 and beyond. The actual Care Transformation Requirements for each MDPCP Performance Year will be specified in the CMS Participation Agreement.

I. TENTATIVE CARE TRANSFORMATION REQUIREMENTS

Comprehensive Primary Care Functions of Advanced Primary Care	MDPCP Track 2 and Track 3 practices must meet the following requirements:
Access and Continuity	<ul style="list-style-type: none"> ● Empanel MDPCP Beneficiaries to MDPCP Practitioner or care team. ● Ensure MDPCP Beneficiaries have 24/7 access to a care team or MDPCP Practitioner with real-time access to the beneficiary’s EHR. ● Ensure MDPCP Beneficiaries have regular access to the care team or MDPCP Practitioner through at least one alternative care strategy.
Care Management	<ul style="list-style-type: none"> ● Ensure all empaneled, MDPCP Beneficiaries are risk stratified. ● Ensure all empaneled MDPCP Beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management. ● Ensure empaneled MDPCP Beneficiaries receive a follow-up interaction from the MDPCP Practice within one week for ED discharges and two business Days for hospital discharges. <p>Ensure empaneled MDPCP Beneficiaries who have received follow-up after ED, hospital discharge, or other triggering event receive short-term (episodic) care</p>

Comprehensive Primary Care Functions of Advanced Primary Care	MDPCP Track 2 and Track 3 practices must meet the following requirements:
	management.
Comprehensiveness and Coordination across the Continuum of Care	<ul style="list-style-type: none"> ● Ensure coordinated referral management for MDPCP Beneficiaries seeking care from high-frequency referral and/or high-cost specialty care providers as well as EDs and hospitals. ● Ensure MDPCP Beneficiaries with behavioral health needs have access to care consistent with at least one evidence-based mental health and/or substance use disorder program for integrated behavioral health supplied to MDPCP Beneficiaries by the MDPCP Practice ● Facilitate access to resources that are available in the MDPCP Practice’s community for MDPCP Beneficiaries with identified health-related social needs
Beneficiary & Caregiver Experience	<ul style="list-style-type: none"> ● Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities. ● Engage MDPCP Beneficiaries and caregivers in a collaborative process for advance care planning
Planned Care for Health Outcomes	<ul style="list-style-type: none"> ● Continuously improve the MDPCP Practice’s performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.